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CIS

IMPACT OF FISCAL YEAR 1982 BUDGET REDUCTIONS ON INDIAN HEALTH SERVICE

HEARINGS

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

FIRST SESSION

ON

THE IMPACT OF FISCAL YEAR 1982 BUDGET REDUCTIONS ON INDIAN HEALTH SERVICE

DECEMBER 21, 1981

BILLINGS, MONT.

AND

FEBRUARY 15, 1982

PHOENIX, ARIZ.

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IMPACT OF BUDGET REDUCTIONS ON INDIAN HEALTH SERVICE

DECEMBER 21, 1981

U.S. Senate,
Select Committee on Indian Affairs,
Billings, Mont.

The committee met, pursuant to notice, at 10:45 a.m., in the City Hall Courtroom, Billings, Mont., Senator John Melcher (acting chairman) presiding.

Present: Senator Melcher.

Staff present: Jo Jo Hunt, staff attorney.

Senator Melcher. The hearing will come to order. This morning we are having a hearing of the Senate Select Committee on Indian Affairs to receive testimony from representatives of the Indian tribes and organizations, and also from the administration, IHS specifically, on the impact of budget reductions on Indian Health Service.

Some of these programs are operated, as you know, under contract. We want to get a real updating on what is happening to the delivery of the Indian health care to Indian people.

Our committee is the authorizing committee in the Senate. We set the basic ground rules by legislation, but we do not actually appropriate the funds. Our recommendations are generally taken very seriously by the appropriations committee in regard to Indian Health Service, and we work very closely with them.

The fact that the Federal budget had to be decreased has placed in jeopardy some of the actual delivery of health care to sick patients.

Where there are hardships created, where there are instances of actual failure to have proper health care, we want to be advised.

No one in Congress will argue with the fact that the Federal budget must be reduced. We are looking at huge Federal deficits. It is alarming to look at what the President will be telling us will be the situation for his proposed budget for the next fiscal year. The indications are that the President will be telling us that there is at least a deficit projected into the budget of $90 billion and perhaps as much as $100 billion. That is not this fiscal year, but in the budget following. When he gives his state of the Union message later in January and then presents his next year fiscal 1983 budget to Congress, he will be talking about that.

Keeping that in mind, I am going to repeat something I have often said over the past 5 years. We want to be sure that every dollar spent for health care through the Indian Health Service for Indian people is a dollar well spent, and we get the full mileage out of that dollar. It is most important that we do.

The committee, in sending me out here for this oversight hearing, wants to be advised on what is really happening to sick patients. We want to keep up with the facts as they are, and whether or not the sick and the programs of prevention of sickness are really working.

Today's hearing involves the Billings and Aberdeen areas only. We want to hear directly from the Indian people themselves, from the various tribes, on just how it is going.

There are health program components which can be reduced. Some of them could be called overhead expenses which can be reduced without any serious jeopardy to Indian health. We need your recommendations on those programs.

We need your recommendations for allocating what divisions there should be between administrative costs and direct services. We want more effective and efficient operation in the Indian Health Service by reducing some of those administrative costs in light of the fiscal austerity program which we are under.

Any recommendations which the tribes or organizations have for the Indian Health Service in this regard are most welcome. We need those recommendations.

Particularly we would like to know what has been the effect in this particular fiscal year, starting October 1. We have almost completed one-fourth of this current fiscal year. We would like to be advised whether the Indian Health Service has been able to keep within these reductions and whether there has been delays, or snafus, or foulups of some kind. I think you are the people who can tell us how it has been working in the past 2½ months.

We have a lot of witnesses today. Those of you who have written testimony, please submit it for the record. Do not read it to me. We will always have that available. We ask you to summarize orally and very briefly what the major points are that you have to present to the committee.

We will attempt to conclude this hearing no later than 1:30 or 1:45, because immediately following, beginning at 2, will be an oversight hearing on Indian housing.

Part of this fiscal austerity has been to try to get these hearings together so that you people who come to testify can do so on both sides; both on Indian health and on Indian housing. Also, that goes for the staff: Jo Jo Hunt here on my left, one of the committee's counsels, and Virginia Boylan, another of the committee staff counsels. It saves their travel time, too. Travel time and travel costs for them as it does for you. So we are trying to keep with reduced funds that are available for our purposes, too. That is the reason for having both hearings on the same day.

If we can be assured that in this area office of Indian Health Service and in the Aberdeen area office of Indian Health Service that progress is being made, then we will know that Indian Health Service is doing the right kind of a job. I have had a major concern over the past 5 years—this is a little bit repetitious—that we have had some breakdown in delivery of actual delivery of the patient care for Indian Health Service in those two areas. The committee will have an oversight hearing in Albuquerque later on, either this month or next month, for three other areas of Indian Health Service. But these two, Billings and

Aberdeen, have been, I think, on the front burner of this committee's concern on whether Indian Health Service is really delivering the dollar's worth of Indian health care for the dollar appropriated.

So with those comments behind me now, we will call on the first panel of witnesses, which is Jessie James, Montana Indian Health Board, Don Bishop—who is representing Fort Belknap? Jessie James is not here.

Ms. WHITE. I have been asked by Jessie James to provide some testimony on her behalf for the Montana Indian Health Board, which she chairs. I do not know what instructions she gave to her tribal health director.

Senator MELCHER. Please come up to the witness stand. Don Bishop, chairman, Montana Intertribal Policy Board, and Clayton Small, executive director of same. Phillip Rattler, Blackfeet Tribal Council and Blackfeet Tribal Health Board, and John Houle, chairman, Rocky Boy Health Board.

STATEMENT OF ADA WHITE, MONTANA INDIAN HEALTH BOARD, FORT BELKNAP HEALTH DEPARTMENT, HARLEM, MONT.

Ms. WHITE. Thank you very much, Senator Melcher. I am sure the public does understand—those who know Jessie James—that her daughter is in critical condition in Seattle. She asked me to come and present some testimony on behalf of the Montana Indian Health Board, and I know that the Montana Indian Health Board has been in direct communication with Senator Melcher's office concerning some of the program operations within the Billings area.

At this point, what I would like to do is briefly summarize the recommendations of the Montana Indian Health Board. I think the advocacy role assumed by the Montana Indian Health Board should be maintained and protected. One, because the State of Montana does have their centralized HSA advisers council, and the Montana Indian Health Board does parallel that kind of administrative setup.

The reason the board is so needed is to serve as a central focal point for the exchange of information within the Billings area; and, also, to assist and maintain a coordinative arm with the management of the Billings area Indian Health Service.

We know that the Montana Indian Health Board did present a proposal to the area office called health, management, and assistance program. The proposal did not receive clearance due to some of the program regs from 638 that said the programs should have clearance from all tribes which they are representing, and many of the tribal health boards were under the assumption that the Montana Indian Health Board was taking funds that would ordinarily go to the local level. Our recommendation is that in no way should the Montana Indian Health Board be in a position to vie for the same category of funds. As a result, we are requesting that the Montana Indian Health Board receive funding from the program management aspect of the area office activities.

The second point that we are strongly recommending is that the proposed budget cuts of Indian Health Service and the related tribal health programs be based on a tribal health level priority system that has been established by representatives from various programs, IHS, tribal CHR's, whomever the budget cuts are going to effect, that we get away from a Federal interpretive position, but that it be really strongly tribal, and the reductions aimed from a tribal position.

The third recommendation we are making, Senator Melcher, is that Deferral No. DA2–212, covering approximately $11 million in Indian Health Service, be freed up from the deferral process. It is our understanding, whether it is unintentional or whether it is manufactured, but we believe Congress is in the midst of a recess right now, taking up a lot of days, and we would like the Oversight Committee to address that very obvious weakness.

Our testimony is really based on the fact that Congress did establish two major goals when they passed Public Law 94–437, that they wanted to insure that the health status of Indian people was brought up to parity with that of the general population; and the second point, to achieve the maximum participation of Indian people in Indian health programs.

Based on those two major goals, we firmly believe that the Montana Indian Health Board should be given due consideration in funding and protecting and maintaining a very jointful, cooperative working relationship with Indian Health Service.

I will, at this time, present copies of this testimony to you, and in addition, because you are restricted for time, I am also presenting written testimony, on behalf of the National Association of Community Health Representatives, and the Billings Area Community Health Representatives.

Specifically, when we are looking at program reductions, I believe we are looking at approximately 36 positions that would be cut out this year: somewhere in that area. This is going to have drastic effect on programs at a local level, and we firmly believe that if services are to be curtailed, that we indeed look at the administrative management aspect and look at direct services, and most importantly, look at field health and what that does.

The written testimony speaks for itself, and I plead with you, Senator Melcher, to look very closely at the written testimony that has been presented on behalf of CHR programs in the Billings area and throughout the country. Thank you very much.

Senator MELCHER. Thank you very much.

The material which you submitted will be made a part of the record at this point.

[The material follows. Testimony resumes on p. 18.]

MONTANA INDIAN HEALTH BOARD TESTIMONY ON THE IMPACT OF THE FISCAL YEAR '82 BUDGET CUTS AND STATEMENT OF NEED CONCERNING INDIAN TRIBAL HEALTH SERVICES

PRESENTED TO: Honorable Senator John Melcher
Senate Select Committee on
Indian Affairs
December 21, 1981
Yellowstone County Courthouse
Billings, Montana

PRESENTED BY: Ada M. White, Vice-Chairman
Montana Indian Health Board, Inc.
1215 24th Street West
Billings, Montana 59102

Honorable Senator, Members of the Senate Select Committee on Indian Affairs:

My name is Ada White; I am a member of the Crow Tribe of Indians, and I am here as the Vice-Chairman of the MONTANA INDIAN HEALTH BOARD, presenting testimony on behalf of this Board.

In the early years of tribal health departments, April of 1971, the MONTANA INDIAN HEALTH BOARD, an Indian controlled organization, was organized at the request and under the supervision of the Billings Area Indian Health Service. Through the continued efforts of representatives from the seven (7) Montana and one (1) Wyoming reservations, non-profit incorporation status was acquired in May of 1974.

The MONTANA INDIAN HEALTH BOARD did accept the challenge of developing tribal options and did assume the responsibility of developing health related programs and activities in addressing the universal concerns of participating reservations. Suffice it to say, the input in the development and enactment of P.L. 93-638, The Indian Self-Determination Act; P.L. 93-437, the Indian Health Care Improvement Act; the Indian Child Welfare Act; the American Indian Policy Review Commission; and other policy determinations aimed at "improvement in the delivery of health services" reflects the sound advocacy role assumed by the MONTANA INDIAN HEALTH BOARD. And, within this process of tribal health departments, the spirit of Indian self-determination and advocacy was realized to its fullest.

This committment and involvement, and the work accomplished within the past decade is, within a very short period of time, placed in jeopardy. The Indian within the State of Montana believe that health care is an entitlement benefit, protected by Indian treaty rights.

Senator---The MONTANA INDIAN HEALTH BOARD directs your attention to:

1. The need for tribal representatives to have, similar to the State HSA Advisory Council, a central focal point--a central health advisory system, who jointly and cooperatively defines and responds to health problems common to all reservations. Attachment A in this testimony concerns correspondence from the Indian Health Service Area Office stating the MONTANA INDIAN HEALTH BOARD proposal, "Health Management Assistance Program", did not receive tribal clearances under the regulations of P.L. 93-638. The result, no funds made available.

   Our concern, Senator, is provided in Attachments B,C,D, wherein tribal groups were placed in the position of making the interpretation that the funding of the MONTANA INDIAN HEALTH BOARD would limit the funds available for local Health Boards.

   The belief of the MONTANA INDIAN HEALTH BOARD is contrary to this. If Indian Health Service funds are identified for the reservation level tribal health system, the MONTANA INDIAN

HEALTH BOARD would not, by intention nor design, covet this funding source. In no way should the MONTANA INDIAN HEALTH BOARD and a tribal health department be placed in the position of vying for the same funds. The recommendation made by MONTANA INDIAN HEALTH BOARD is for the funding to be made available from the Program Development and Program Management categories of the Indian Health Service Area Office budget.

2. The proposed budget cuts of Indian Health Service and related contracted tribal health programs should be based on a "tribal-level health priority system" based on participatory representatives, as opposed to federal interpretations so that the options developed for the proposed reductions safeguard and maintain a high, healthy level of direct services for Indian people.

3. A recommendation is made by the MONTANA INDIAN HEALTH BOARD: That deferral No. D82-212, covering approximately 11 million in Indian Health Service funds be freed from the deferral process and be made available for distribution and utilization by Indian Health Service. Whether by intent or design, the 60 day notice period does fall right in the midst of the holiday season, with Congress in recess, and a mechanism not

available to address this obvious weakness. As a result, the MONTANA INDIAN HEALTH BOARD does bring this to the attention of the Senate Select Committee on Indian Affairs.

Senator---the MONTANA INDIAN HEALTH BOARD is cognizant of the demands placed upon public officials and public representatives. This demand is not assumed lightly. The service area of the MONTANA INDIAN HEALTH BOARD results in a unique, broad-based set of responsibilities not attributed to any one of the reservation level boards. The need for a coordinating arm for regular and consistent communication with the Indian Health Service Area Office is predicated on two major goals expressed by Congress in passing P.L. 94-437:

1. to ensure that the health status of Indian people is brought up to parity with that of the general U.S. population, and,
2. to achieve the maximum participation of Indian people in Indian health programs.

Thank-you Senator Melcher, for providing this session, whereby the concerns of the MONTANA INDIAN HEALTH BOARD will be shared with the U. S. Congress.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION

NOV 5 - 1981

BILLINGS AREA
INDIAN HEALTH SERVICE
2727 Central Avenue
P. O. Box 2143
Billings, Montana 59103

Our Reference: TP

Ms. Jesse James, Chairperson
Montana Indian Health Board
1215 24th St. West, Suite 210
Billings, MT 59101

Dear Ms. James:

The Montana Indian Health Board proposal entitled, "Health Management Assistance Program," was received on August 20, 1981.

The regulations governing P.L. 93-638 contract proposals are found in 42 CFR 36.206 - Tribal Clearances - initial contracts and 36.207 - Tribal clearances - renewal contracts. The MIHB proposal falls under 36.207 (b). Briefly stated, that regulation requires that a tribal organization providing services to more than one Indian Tribe must give a copy of the contract proposal to each tribal governing body at least 75 calendar days before the original contract expires. The tribal governing body would then have 45 days from receipt of the proposal to issue a formal resolution objecting to the proposal. If one or more of the tribal governing bodies involved object to the renewal, the contract will not be made until all the tribal governing bodies have approved the request or the matter is resolved.

Five tribal governing bodies, Blackfeet, Crow, Flathead, Fort Peck, and Rocky Boy have submitted formal objections to the proposed contract renewal. Pursuant to 42 CFR 36.207 (b), we cannot proceed with the contract award process until all tribal governing bodies have approved or the matter is otherwise resolved.

Sincerely,

Robert LaFromboise
Robert LaFromboise
Assistant Area Director, Indian
Community Health Development Programs

ATTACHMENT A

RECEIVED
NOV 6 1981
MONTANA INDIAN
HEALTH BOARD

Copy sent to J James 11/6/81
Copies made for Bd members

The Chippewa Cree Tribe of the Rocky Boy's Reservation

Phone 395-4478 or 395-4727 · Rocky Boy Route · Box Elder, Montana 59521

RECEIVED
SEP 29 1981
MONTANA INDIAN
HEALTH BOARD

September 24, 1981

Ms. Jesse James, Chairman
Montana Indian Health Board
1215 24th Street, West
Billings, MT 59103

Dear Mr. James:

The Rocky Boy Health Board members and the Tribal Business Committee reviewed the Montana Indian Health Board proposal requesting the amount of $182,000.00. Our Tribal Business Committee through the Health Board decided not to support this full amount requested.

It is the request of the Business Committee that any monies which may be available be given to the local Health Boards.

Enclosed in this letter is a formal resolution passed by the Health Board.

If you have any questions, please call or write.

Sincerely,

Thomas Parisian, Secretary
Rocky Boy Health Board

Enclosure

cc: Area Director, Jim Smith
Lazona Bailey, Acting Director
Montana Indian Health Board

Approved by: John Windy Boy, Chairman
Chippewa Cree Tribe

Attachment B

THE CONFEDERATED SALISH AND KOOTENAI TRIBES
OF THE FLATHEAD RESERVATION

(406) 675 - 2700

Box 278
Pablo, Montana 59855

Fred Houle, Jr. Executive Secretary
Vern L. Clairmont Executive Treasurer
Al Hewankorn Sergeant at Arms

TRIBAL COUNCIL MEMBERS
[illegible]
[illegible]
[illegible]
Joseph E. McDonald [illegible]
[illegible]
John McClure
E.W. Morigeau
[illegible] Morigeau
[illegible]
[illegible]

September 25, 1981

Refer to:

Tribal Health Department
P.O. Box 340
St. Ignatius, MT 59865

RECEIVED

OCT [illegible]

[illegible]
HEALTH BOARD

Ms. Jesse James
Chairperson
Montana Indian Health Board
1215 24th St. West
Billings, MT 59107

Dear Ms. James:

In response to the Montana Indian Health Board's proposal for FY 82 entitled "Health Management Assistance Program" calling for the obligation of $182,805.00 in Tribal Management Support funds, the Flathead Tribal Health Board has taken the following positions:

1. While the Board is desirous in supporting and participating in the continued operation and development of a strong Montana Indian Health Board it does not deem the FY 82 MIHB proposal appropriate when placed in the broader context of Tribal/Indian Health Service problem resolution priorities for this upcoming fiscal year. Funding the MIHB for the proposed amount would have a devastating impact on the budgets and corresponding ability of Tribal Health Boards and Departments to constructively impact Reservation health problems.

2. The Flathead Tribal Health Board recommends that the MIHB not seek funding for an administrative staff in FY 82 and instead, focus on coordinating administrative needs with the Montana Inter-Tribal Policy Board while working on a long range plan (five year goals) and a short range plan (Annual Implementation Plan) to guide the Montana Indian Health Board along a course set to provide local Health Boards and Departments maximum flexibility and options from the Billings Area Office in dealing with local health problems.

Should you have any questions or be in need of any clarification on either of these positions please advise at your earliest convenience.

Sincerely,

TRIBAL HEALTH BOARD

Dorothy Webster, Chairperson

Attachment C

BLACKFEET HEALTH BOARD
P.O. BOX 866
BROWNING, MONTANA 59417
PHONE 338-[illegible] 2531

September 9, 1981

Ms. Jesse James
Chairperson
Montana Indian Health Board
1215 24th St. West
Billings, MT 59103

Dear Ms. James:

This letter is being submitted to your office in response to the proposal for funding for the Montana Indian Health Board in the amount of $182,000.00. The Blackfeet Tribal Health Board is not desirous of supporting this request.

However, the Board feels that the communications between the Tribes in the Billings Area is essential, and are in hopes that if any monies are to be used for funding of this organization, they should go directly to the Tribes. Priority should be given to the local Health Departments, with second priority given to the Area Board concept.

Mr. Jim Kennedy will be delegated to deliver this letter to your office, and if any further questions need be answered, feel free to contact our office.

Sincerely,

Mary Jo Walter

Mary Jo Walter, Chairperson
Blackfeet Health Board

/cw

Attachment 10

JOINT ISSUANCE: NATIONAL ASSOCIATION OF COMMUNITY HEALTH REPRESENTATIVES
BILLINGS AREA ASSOCIATION OF COMMUNITY HEALTH REPRESENTATIVES

STATEMENT BY: Ada White, President, NACHR, INC.
President, BACHR

Senator Melcher and members of the Senate Select Committee on Indian Affairs:

The statement that best describes and perhaps accurately sets the mood for my presentation is based on a quote from a statement made in 1978, by the former Director Of Indian Health Service, Dr. Emery Johnson:

> " The cataclysmic economic events of the 1930's and the great wars of the 1940's and early 1950's left special Federal Indian health services in a deplorable state, with poor, out-dated, understaffed, ill-equipped, and under supported facilities and programs. Inevitably, those decades of such adversity took their toll on the health of Indian people. Diseases which had been all but eliminated from the general population continued to ravish the poorly protected Indians. Tuberculosis, for example, wiped out hundreds of Indians and chronically disabled thousands each year. People of all ages throughout Indian Country were struck down by preventable illnesses and premature death, with infants being being especially hard hit. The health status of Indians lagged about a generation behind that of the general American Public. It was perfectly clear to the Indians and all others that these terrible conditions and circumstances were shockingly, outrageous and absolutely intolerable in the United States of America of the day and age. To allow them to continue would be inexcuseable. The finding of a remedy for the Indians' health problems and their causes, therfore, became a governmental imperative."

The subsequent response from Congress and the various departments within the Federal Government resulted in the development of unique approches in the response to health problems of this Nations Native population.

One program perhaps the one best know as the pioneer in the development of a tribal health program, is the Community Health Representatives Program (hereafter referred to as the CHR Program). Since the CHR Program was first initiated in 1968, approximately 2,434 tribal members on reservations throughout the country have been trained and employed as CHR's. The primary intent of the CHR Program was to bridge the communication and cultural gap between the community and those providing health care. According to Ralph Myhre, Health Educator, from the Billings Area Indian Health Service:

> " The CHR Program is a unique component within the Health Delivery System of the Indian Health Service for the provision of health services on the reservation and Indian Community...The CHR has served as a member of the health team, yet is not an employee of the Indian Health Service or any local agency. The CHR is an employee of the tribal group with whom he lives. It is the Tribe whom he represents and to whom he is responsible. His role is to

> serve his people as an advocate for better health and related services."

Although the descriptive document, COMMUNITY HEALTH REPRESENTATIVES, A Changing Philosophy of Indian Involvement was written in 1970, the four basic program tupes are still relevant: the health aide program, characteristic of CHR's who provide assistance to specific Indian Health Service personnel in both clinical and field health programs; the health liaison program which emphasizes the liaison activities between community and health resources; the community liaison program, which focuses on liaison activities between the community and all outside resources; the community development program, which emphasizes the methods as well as the goals of CHR involvement. The CHR involved in this type pf program utilizes community organization skills in identifying and solving health problems.

Each CHR Program in the country does exhibit some of the traits described. The early years of CHR activity clearly emphasized the latter three, which meant, CHR assignment emphasized liaison and community development activities.

Indian Health Service safely accepted the interpretation that medical problems confronting Indian people covered both the common medical kind needing attention from an array of related health professionals; and also, those problems arising out of the so called "social fabric of the community". The facts speak for themselves, as evidenced: in the hospital admissions noted for FY 79, 80,700; the outpatient clinic visits having risen from 455,000 in 1955 to 3, 227,000 in FY79; and the accident rate being 3 1/2 times as high in comparison to the general population; with the age adjusted death rate from cirrhosis of the liver being 5 times as high as the rate among Americans as a whole. In view of these statistics, the connection between direct services and field health efforts would be difficult to seperate.

If we are to believe that the proper approach to attacking socially based medical problems means more then treating the medical symptoms, for some attempts must be made to explore for the root causes, with remedial action taken. Given the pluralistic considerations, the continuance of a cross-cu;tural approach in the delivery of health care to Native Americans must be maintained and protected.

To but it clearly, the CHR Program must continue to recieve funding from Congress. The CHR must reqieve priority treatment in the scaling down of Indian Health Services. The condition which existed and strongly supported the need for CHR Programs are still present, those indicators being: the remote locations; the lack of transportation; povertu; limited employment; inadequate and limited living conditations; mutual suspicion between Indians and non-indians; unawareness or lack of knowledge regarding existing resources and the inability to communicate across cultural barriers.

The following Billings area statistics are shared, and will be forthcoming from other aeeas:

Page three, Testimony from Ada White, 12-21-81

FOR THE BILLINGS AREA CHR PROGRAM:

1. The 1981 workload data: 130,900 services and 145,600 contacts; with anticipated reduction in staff, there would be a loss of 27,600 services and a loss of 30,576 contacts.

2. The 1981 personnel listing:

   170 CHRs total
   22 Administrative/clerical
   71 Generalist
   73 Specialist
   159 Current Filled

   With the projected decrease in FY 1982, a 21% decrease equates an approximate loss of 36 positions less than the FY 81 or 134.

THE CONCERNS AND RECOMMENDATIONS OF THE CHR PROGRAMS:

1. That the proposed reduction in health services for Native Americans be curtailed as soon as possible; that the health services classifications, curative-direct, preventive and rehabilitative be viewed in their entirety and due value placed on each category.

2. That CHR position reductions be determined by those people involved in daily operations of CHR programs in cooperation with other programs (tribal, IHS, etc.),

   a. That specialist and generalist positions be given equal assessment,

   b. That field health efforts be viewed by specialty assignment and not lumped as "generalist"

   c. That seniority and length of service be given special merit

   d. That educational assessment and salary ranges be quoted within context.

3. That the funding authorities utilized by IHS and tribal groups be tailored to suit the needs, purpose, and intents of CHR programs. For example, each tribe within the Billings Area have a CHR program under contract with IHS. There are four programs operating under a master contract (which is probably 93-638); two programs under 93-638 contracting authority; and two operating under the Buy-Indian contracting authority.

4. That those funds allocated by Congress for CHR positions, retain the title and accountability of services as CHRs.

5. That the routing and distribution of a special Senate Report issued January, 1981, be ascertained and reviewed.

6. That a representative (IHS-Tribal-Tribal Health-CHR) review team be established to explore the current tribal health systems and determine the feasibility of staffing patterns and effects on health service staff reductions.

7. That any current and anticipated cutbacks in the CHR program be based on reduction criteria established locally.

8. That annual educational experience for CHRs be stressed and valued as a mechanism in acquiring current information on the changes within the health care priority system.

Most CHR's are not identified as health technicians as such. Most CHR's serve generally across the broad area of health needs. According to Dr. Emery Johnson: "A great deal of credit for health improvements can be attributed to the tremendous efforts of the health team of which the CHR is a vital part. Since 1955, the infant death rate has declined 84%; the pneumonia death rate decreased 57%, and the death rate from certain diseases of early infancy declined 81%. These improvements have been made possible because of Congressional determination to abide its committment to a long-term investment to the betterment of the health of Indians."

Senator Melcher. Donavan Archibald, are you representing the Fort Belknap? You do not need to stand up. You may give your testimony seated.

STATEMENT OF DONAVAN ARCHIBALD, MONTANA INDIAN HEALTH BOARD, FORT BELKNAP HEALTH DEPARTMENT, HARLEM, MONT.

Mr. Archibald. The other half of what Jessie had in mind presenting to the committee today was some problems that we see on the reservation level, and those are threefold.

No. 1, we feel there is a lack or poor management practices of delivery of services from the area office here in Billings. It appears that the area director surrounds himself with assistants, special assistants, whom we never see on the reservation level, and we see no purpose for their being.

Any policy decisions that are made here at the area level, the tribes have no input in these kinds of things, and they bear directly on the well-being of the tribes. We feel that we should be included in these kinds of decisions.

We also feel that the funding cuts, budget cuts, this year have drastically reduced the effectiveness of the tribal health department programs, and the cuts that are actually being made, in order to meet the budget guidelines, are being made at the reservation level, and we feel they should not be made there. They should be made beginning here and on up to the bureaucracy. The tribal health department at Fort Belknap has been cut 66⅔ percent, and we do not see where the——

Senator Melcher. How much was it before, Donavan?

Mr. Archibald. Are you talking dollarwise?

Senator Melcher. Yes.

Mr. Archibald. Dollarwise, we were cut quite a bit more. But I was talking about positions.

Senator Melcher. Dollarwise.

Mr. Archibald. Dollarwise, I would say we were cut somewhere in the neighborhood of 75 to 80 percent.

Senator Melcher. I mean in dollars.

Mr. Archibald. Pardon?

Senator Melcher. How many dollars is that?

Mr. Archibald. From $250 some thousand to $70,0[illegible]e have a core staff that is doing very little except monitoring othe[illegible]ograms.

Senator Melcher. Are those all Federal dollars or are those partly tribal dollars?

Mr. Archibald. Those are all Federal dollars.

Senator Melcher. Please, proceed.

Mr. Archibald. And the other part of it is that even on a service unit level, we have programs, health education, the dental program, some of the other programs that are restricted in travel, supplies. We have a position sitting there drawing a salary but it cannot provide the service. And, I believe that those people should be utilized. The cuts should come from areas other than the tribal level.

The second point was the distribution of program fund 638 moneys. We are asking the committee to review the indirect costs, rates, and how they are established by the agencies that do establish direct cost rates.

Senator **Melcher**. We are doing that.

Mr. **Archibald**. OK.

Senator **Melcher**. That covers a broad array of programs.

Mr. **Archibald**. Yes, it does.

The other thing is, again, the distribution of funds. There are, we feel, some irregularities and possibly illegal use of funds in the Brigham City service unit that were probably known here in the area but nothing has been done. We have documentation submitted to your office already, and if you need further documentation, we will provide that.

The third part that we would like is in the area of personnel policies. Recently we feel that two people who played an integral part in the providing of health services and serve as a liaison between the tribes and the area office has been eliminated from service due to some things that we feel were not really justified. They were terminated, and we feel they did provide us with the service. I think that the administration here in the area level could well be looked at in terms of their providing services to the tribes. The elimination of these people's positions, I think, are used as a measure to meet the cuts in the budget in the overall area. That's fine, you know, but, again, I would like to emphasize that those cuts should come at this level and not at the service unit level or the reservation level.

Finally, we feel that these practices, and so forth, in management policy and fund distribution should be looked at and reviewed thoroughly by the committee and recommendations made to us as to how we can get around or meet the problems that they have presented to us; because we are not getting the services.

Senator **Melcher**. You will be here through the balance of this hearing?

Mr. **Archibald**. Yes, I will.

Senator **Melcher**. Well, we will see what documentation we might ask for later on.

Don Bishop. Is Don Bishop here? Phillip Rattler?

Mr. **Rattler**. Senator Melcher, at this time I would like to introduce the chairman and chief of the Blackfeet to give the next testimony.

Senator **Melcher**. Did you want to testify, Earl?

Mr. **Old Person**. We have a separate testimony here, if you will allow us after the intertribal?

Senator **Melcher**. Is Don Bishop or Clayton Small here? There is no intertribal policy board testimony.

Unidentified Speaker. Mr. Chairman, Clayton Small will have to be a late arrival.

Senator **Melcher**. We will take his written testimony and then proceed to the Blackfeet. Who wants to testify for the Blackfeet? We have to keep this hearing going.

STATEMENT OF EARL OLD PERSON, CHAIRMAN, BLACKFEET TRIBE, BROWNING, MONT.

Mr. **Old Person**. Senator Melcher, I am also calling Jim Kennedy, who is chairman of our health board of the Blackfeet people. We have testimony that will be submitted to you, but I just want to speak in general at this time. As you know, this is just one more time that we are coming before a committee and talking about the effects due to the budget cuts that have been made. I have already stated, many times, that the No. 1 importance to people, not just Indian people, but to all people, is health. If we do not have the health, we cannot function.

The Indian people are having one of the most difficult times, at this time, trying to keep within the budget cuts that are now in effect. In times before, the Indian people have had difficulty in trying to work with the kinds of funds that were directed to them in order to prevent health problems within the Indian reservations. This administration's cuts certainly cause more difficulties and more frustration to those people who have to deal and work with these kinds of problems.

We certainly want to thank your committee, Senator Melcher, for allowing the Indian people this opportunity to express their opinions, their thoughts, and what they see that is going to cause the effects and the problems for the Indian people. We also want to thank you for helping the Indian people, to the extent that you can, with the appropriations committee.

I think one of the things that the Indian people are looking for is for someone to begin to listen to these kinds of testimonies, to these kinds of positions, papers that are submitted to your committee, to the central office, to those people that we are looking to for help.

The Blackfeet people's priority at this time in the funding of the health field is direct patient care. This is within the Indian Health Service budget as far as hospitals and clinics are concerned.

We have caused our Indian people, especially our elderly people, to change from what they used to be and what they used to do. They have changed from their tradition, their culture, in medicines. We have convinced them that they must go this other way, in a modern way, and now that we have convinced them to go that way, we are having a hard time accommodating them in the way we caused them to go. So I do not know what more the Indian people can say with all the papers, with all the concerns, the positions, that they have submitted already; but to say again, that we are in need of some attention, someone to listen to those needs that we are again presenting at this time.

At this time I would like to ask Mr. Kennedy if he will elaborate a little bit on some of the specifics that we have within the Blackfeet area.

STATEMENT OF JIM KENNEDY, CHAIRMAN, TRIBAL HEALTH BOARD, BLACKFEET TRIBE, BROWNING, MONT.

Mr. KENNEDY. Pertaining to direct patient care; across the board IHS has imposed a 10-percent cut, not taking in the factor of the inflation rate. The cost of medicine has been increasing. As you can see by our testimony, it shows a deficit in the Blackfeet service unit for direct patient care of $778,000, not including dental. Our dental problem, on the Blackfeet Reservation, is running 95 percent, including adults and children. This has been severely cut back.

We are willing to live with certain cuts and we realize Mr. Reagan's plans for stabilizing the Nation's budget. We support it. However, when it comes to lives and health, it is a different story.

With that, I would like to close and thank you very much for the time that you have allotted us.

Senator MELCHER. I want to thank both of you for this very well-prepared written testimony and the documentation that accompanies it. It is very helpful to the committee. It will be made a part of the record at this point.

[The material follows. Testimony resumes on p. 52.]

SENATE OVER SIGHT HEARING
BILLINGS, MONTANA
DECEMBER 1981

Honorable Senator Melcher, my name is Earl Old Person, Chairman and Chief of the Blackfeet People. Through me, the Blackfeet People would like to thank you for the opportunity to present problems that have risen due to the federal cut-backs imposed by the Reagan Administration.

The Blackfeet Tribe would like to began by thanking you and the Appropriations Committee for the outstanding work on behalf of the Blackfeet Tribe and it's attempts to secure a new hospital for the people living on the Blackfeet Reservation.

The number one priority for continuation funding in the health field for the Blackfeet Tribe is direct patient care, which is listed in the I.H.S. budget as hospitals and clinics.

The utilization of hospital services at the Blackfeet Reservation is the highest of any reservation in the Billings Area. The following data for FY1981, gives some idea of the high utilization:

UTILIZATION OF HOSPITAL INPATIENT SERVICES - IHS & CONTRACT

FY-1981

	Hospital Days Per Person IHS & Contract
Blackfeet	1.61
Average - Billings Area Except Blackfeet	.99

UTILIZATION OF CONTRACT INPATIENT SERVICES AT RESERVATIONS WITH IHS HOSPITALS

FY1981

	# of Hospital Days Per Person - Contract Hospital
Blackfeet	.53
Crow/Northern Cheyenne	.43
Fort Belknap	.39

The CHS expenditures reflect the higher utilization of hospital services at the Blackfeet Reservation. Their expenditures for FY1981 was $1,727,748 (excluding dental). This was $152,000 in excess of the CHS budget allowance for the Blackfeet Reservation. Of the $1,727,748, $1,261,172 was spent for inpatient services.

The beginning of FY1982 is a continuation of the problems experienced in FY1981. The Blackfeet Service Unit has obligated funds at the rate of $4,193 per day. Available funds (FY1981 less 10%) would indicate that they should be operating at an obligation rate of $3,350 per day. If available funds are not increased or the obligations reduced, the FY1982 deficit at the Blackfeet Service Unit would approximate $300,000.

For the CHS program to operate at the same level of service in FY1982 as in FY1981, they would need a $2,000,000 budget. The difference between FY1981 less 10% ($1,222,000) and the $2,000,000 need is $778,000.

Over the years, the I.H.S. has utilized various process in allocating resources for health services. In partial fulfillment of the requirements of the Indian Health Care Improvement Act, Tribal Specific Health Plans were developed. The development and utilization of these plans represent a new planning process for the I.H.S. and Indian Tribes.

In order to establish priorities amoung program elements, such as inpatient care, emergency care, ambulatory care, ect., a level of health service needs must be established for each Tribe.

The resource requirement identifed for Tribal Specific Health Plans are those resources needed to provide comprehensive quality health services. The total available resources include resources provided by I.H.S. as well as other federal, state and private resources available to the Tribes. The available resources are subtracted from the total resource requirements, with the difference being the additional need or unmet need. The present deficiency is then determined by dividing the unmet need by the total resources required.

Having identified the additional resources required for the Blackfeet Service Unit, the level of deficiency for the Blackfeet Service Unit was found to be approximately 50 percent deficient during FY81. However, during the period from October 1, 1981 to December 15, 1981, the deficiency has increased to a level where only cases involving life and death are being refered out to major medical providers.

The Blackfeet Tribe recognized the fact that there should be less federal intervention in state matters, however, in regard to Indian Tribes, many of the proposed program reductions are counterproductive.

Prior progress and improvements do not mean we have reached the goal of raising the health status of Indians to the highest possible level, we haven't. The health status of Indian people continues to lag behind those of the general population.

Again, the facts tell us that much remains to be done before that long sought after goal is reached.

Statistical health status comparisions are very revealing facts, they tell us about much needed change.

The Native American comprises the largest racial minority group in Montana, accounting for approximately four percent of Montana's total population. This racial minority experiences a lifestyle which contrasts sharply with the general population. Many Blackfeet have retained aspects of their traditional culture, which tends to alienate them from the mainstream population. Some, especially the elders, speak little or no English. The standard of living is low, and many are deprived of such life serving necessities as good nutrition and a sanitary environment. Educational and employment opportunites for the Blackfeet are limited. Many Indian people live in isolated, rugged areas where climatic conditions can be harsh.

Under such conditions, a number of health related problems are evidenced in high proportions amoung the Indian people. Some of the most serious problems evidenced are accidents, respiratory diseases, alcoholism, and mental health diseases. Other major health concerns include infective and paracitic diseases, maternal and child health problems, and skin infections.

The health problems of the Blackfeet are further exemplified through statistical comparisons with the general, all races, United States population. In fact, it has been said the the health statistics of the American Indian lags 15 to 20 years behind the U.S. population.

For instance, the Blackfeet death rate for cirrhosis of the liver is six times greater than the general U.S. population, five times greater for accidental deaths, and two time greater for infant mortality. Dental disease amoung the Blackfeet affects over 95 percent of the population.

These illustrative examples mean the I.H.S. was making progress in pursuit of it's goal. More improtantly, Indian people, yound and old, were making progress in their quest for better health.

The Blackfeet Tribe supports President Reagan's intention to balance the Nation's budget, however, when lives are severely jeopardized at Mr. Stockmen's fiscal plan; policy has to be questioned. Attached to this testimony, are several memorandums concerning federal cut-backs to the Amercian Indian, pertaining to direct health care.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Billings Area IHS
Policy Bulletin No. 82,13
November 30, 1981

Memorandum

Date NOV 30 1981

DEC 07 REC'D

Refer to: CHS

cc: De Pries
Valerie Goes
Dean Anderson
CHS
ENT Program
Tribal Health

From Director, Billings Area
Indian Health Service

Subject Otitis Media

DEC 2 198

To All Service Unit Directors

Since its beginning ten years ago, the otitis media program has reduced the incidence of serious ear disease from a level three times the national level to slightly less than the national average. This has been accomplished through an intensive program of early identification, early medical intervention and judicious use of minor surgical procedures.

In order to maintain the low level of complications from this problem and at the same time reduce the cost of the program to a minimum, the following steps will be taken:

1. All non-emergency ENT related surgery will be scheduled in the IHS facilities. This will allow the savings of hospitalization costs plus negotiation of a favorable surgical and anesthesia fee.
2. Communication Disorders Program will use otitis media funds to pay surgeon's and anesthesia charges, thereby reducing the cost to contract care to a minimum.
3. Communication Disorders Program will establish a priority basis treatment protocol assuring that only the most necessary surgical procedures are carried out.
4. Communication Disorders and service unit personnel will provide close observation, treatment and recall of existing problems in order to limit the sequelae of the disease.

A regularly scheduled otologic surgery clinic will be held at both Crow and Browning hospitals on a monthly basis. Cases will be referred from all service units. Every effort will be made to contract with otolaryngologists currently providing services so that continuity of care would be maintained. This approach can prevent a reoccurrence of the problems which existed prior to the emphasis on otitis media. It will cause some inconvenience and changes in current procedures. It will require close cooperation between service units, hospitals, surgeons, and the Communication Disorders Program. This cooperation can result in a significant savings in contract care monies, as well as providing the best possible care to Indian patients under difficult circumstances.

There will remain a small number of ear surgeries that represent an emergency condition which may be obtained through Contract Health Service resources. It is recommended that those cases be discussed with Mr. Lewis before referral is made.

It is also suggested that each case be reviewed carefully for alternate resources and where available, the individual should be referred to contract sources rather than to the IHS program.

R G Raymond
for J. R. Smith

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Refer to: CHS r
cc: Do. Peres
Valerie Moss
Dean Anderson
Shirley Sjaavik
Tribal Health

DEC 14 REC'D

Date: December 8, 1981

From: Director, Billings Area
Indian Health Service

Subject: Billings Area IHS Policy Bulletins No. 82.6 and 82.14

To: All Service Unit Directors

DEC 5 198

Attached are Billings Area IHS Policy Bulletins No. 82.6 and 82.14 which are being reissued.

The only change is the time element:

FROM: 60 (sixty) minutes driving time or travel time

TO : 90 (ninety) minutes driving time or travel time

Please either destroy those bulletins stating 60 minutes or PEN AND INK change to read 90 minutes.

J. R. Smith

Attachments:
BA IHS Policy Bulletin No. 82.6
BA IHS Policy Bulletin No. 82.14 (cover page only)

EPARTMENT OF HEALTH & HUMAN SERVICES

November 12, 1981
December 8, 1981 Revised

Memorandum

November 12, 1981

Refer to: CHS

m Director, Billings Area
Indian Health Service

Subject Outpatient Services Charged to Contract Health Service Funds

To All Service Unit Directors

The use of Contract Health Service funds at the Flathead Reservation to support the outpatient visits to the individual's selected physician for routine health services will be continued except that physical examinations will not be paid for after the date of this memorandum.

The use of Contract Health Service funds at the Intermountain school to support the costs of the physician outpatient services at the Health Center will be continued.

The use of Contract Health Service funds for college students outpatient visits will be continued to the extent that the service is not available at the school infirmary or health center as part of the tuition or fees paid by the student and to the extent that the service is not available in an IHS facility that is within 90 (ninety) minutes driving time; e.g. services to students in Billings would be provided at Crow Agency and services to students in Havre at Rocky Boy or Harlem.

Contract Health Service funds may be used to pay for referral of patients to specialist when the specialist examination is required to prevent serious morbidity or mortality. This will apply to the Flathead Reservation and to the Brigham City Health Center as well. All requests for referrals should have prior approval from the CHS Committee before the appointment is made. Exceptions may be approved where the condition of the patient precludes review by the CHS Committee prior to the service.

Contract Health Service funds may be used to pay for emergency outpatient visits, including the cost of emergency room, when the contract facility was the nearest facility able to treat the emergency.

Non-emergency outpatient visits that are not identified as an exception above will not be authorized for payment.

J. R. Smith

Billings Area, IHS
Policy Bulletin No. [illegible]
(4 Pages)
December 2, 1981
December 8, 1981 Rev.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Refer to: CHS

Date December 2, 1981

From Director, Billings Area
Indian Health Service

Subject Payment for Admissions to Contract Hospitals

To All Service Unit Directors

Contract Health Service funds may be used to pay for hospital and physician costs related to services in a contract hospital under the following circumstances:

A. Patients within 90 minutes driving time of an IHS Hospital:
   1. Payment will be made when the admission was for an emergency condition and the contract facility was the nearest facility able to treat the condition.
   2. Payment will be made for admissions to contract facilities where the condition was an emergency and the condition could not be treated in the IHS facility because it required skills and/or equipment not available in the IHS hospital.

B. Patients more than 90 minutes travel time of an IHS Hospital:
   1. Payment will be made when the condition was an emergency where the appropriate treatment could only be provided in an inpatient facility.

The definition of an emergency will be "any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual." Examples of conditions that have been determined to be emergencies are shown in Attachment I. This list is not exhaustive. Other conditions may be included when so determined by the Service Unit CHS Committee.

Questions that arise at the Flathead Service Unit that cannot be resolved based on this policy should be referred to the Area Quality Assurance Officer for his recommendation.

J. R. Smith

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
Health Services Administration
Indian Health Service Hospital
Browning, Montana 59417

NON-EMERGENCY CMC REFERRALS

Due to severe shortages of Contract Medical Care Funds this year, the Service Unit has been informed that referals may be authorized only if death or serious disability would result if the referral were not immediately made. This means that many medically indicated but non-emergency referrals must be indefinitely postponed.

Your doctor feels that your condition requires consultation with Dr. ________________. Since your problem is not an emergency, though, Contract Care funds cannot be used to pay for the referral at this time. We do not know whether money will be available later in 1982 to pay for the referral. If you wish to be responsible for paying for this consultation, our Contract Care Office will assist you in arranging the appointment.

We regret that not enough money is presently available to enable IHS to pay for your health care.

Shirley will distribute this to patients referred but not scheduled for consultations, due to current CMC policies. Hopefully, this will give us some legal protection.

Medical

Acute renal failure

Airway obstruction

Anaphylaxis

[illegible],
acute

Angina pectoris

Appendicitis

Arrhythmias, Cardiac, acute

Asthma, acute attack or status
asthmaticus

Bronchopneumonia

Burns, second and third degree,
chemical, electrical, thermal

Cerebral vascular accident, acute

Spine, ruptured disc, acute

Coma

Concussion

Convulsions, acute

Cyanosis

Delirium tremens

Diabetes mellitus with coma or
ketoacidosis

Drowning (near)

Dyspnea due to asthma, pulmonary
embolism, airway obstruction,
congestive heart failure

Eclampsia

Edema, pulmonary, acute

Embolism cerebral & pulmonary

Encephalitis

Epiglottitis

Epistaxis (nosebleed), severe uncontrolled

Glomerulonephritis, acute

Heat exhaustion & prostration

Hemophilia with acute bleed

Hemoptysis, severe

Hematemesis

Hemorrhage, severe or uncontrolled

Hypertension, acute crisis

Hyperthroidism, crisis

Hyphema, acute

Hypoglycemia, severe

Hypotension, acute

Kidney failure, acute

Kidney stones, acute attack

Larynx, foreign body

Meningitis

Menorrhagia, profuse

Migraine, acute attack

Myocardial infarction

Myocardial ischemia

Orchitis, acute

Pancreatitis, acute

Paralysis, acute

Pelvic inflammatory disease

Peritonitis

Pneumothorax

Poisoning

Preeclampsia

Psychoses, acute

Seizures, acute

Sepsis

Shock

Suicide attempt

Thromboembolism

Thrombophlebitis, acute

Urinary obstruction, acute

Uveitis

Varices, esophageal bleeding

Venomous bites

B. Surgical or Traumatic

a) Amputations, traumatic

b) Burns, second and third degree

[redacted]

d) Crushing injuries

e) Traumatic perforation of the ear drum

f) Electrical burns

g) Eye injuries, corneal abrasions, foreign body, trauma, corneal ulcer

h) All compound fractures

i) Gunshot wounds

j) Head injuries with concussion or subdural hematoma

k) Strangulated hernia

l) Lacerations involving major structures; i.e., tendons, nerves, vessels

m) Pneumothorax

n) Rape

o) Skull fracture

p) Stabbing

q) Torsion of testes

r) Labor and delivery (other factors; i.e., normal vs. complicated, term or pre-term, etc.)

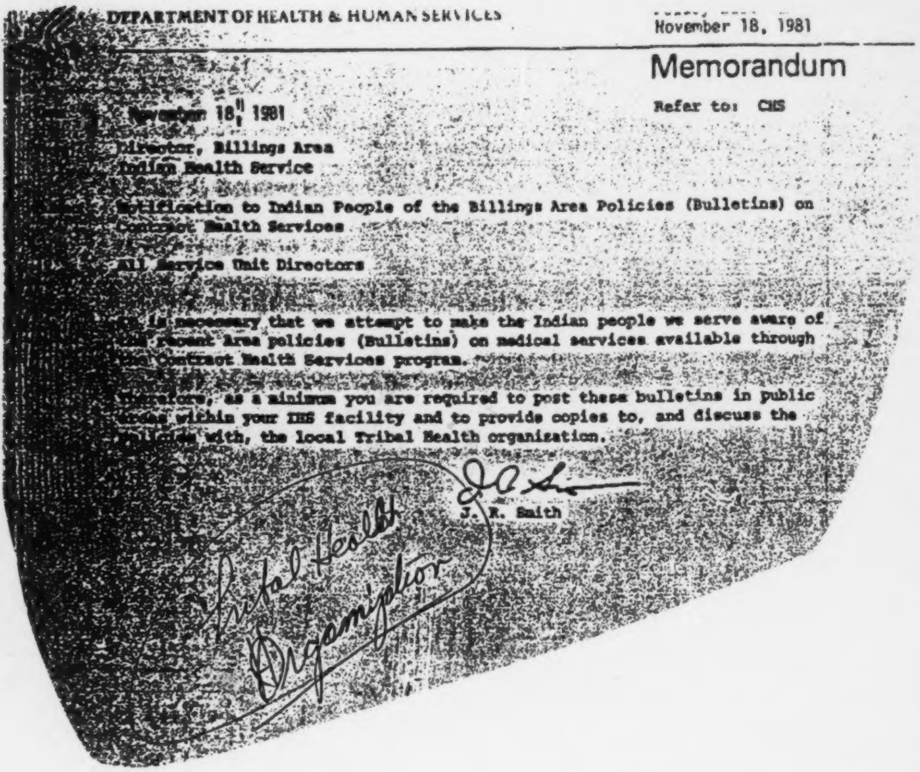
C. Pediatric Emergency

Any acute condition in a patient under one year of age.

D. Alcoholism

If accompanied by any of the above acute medical or surgical problems.

Alcoholism in and of itself is not an admittable emergency. Alcoholic patients without other concomitant medical-surgical problems should be referred to a detox facility as provided by the Tribal Health Board.



DEPARTMENT OF HEALTH & HUMAN SERVICES

November 18, 1981

Memorandum

Refer to: CHS

November 18, 1981

Director, Billings Area
Indian Health Service

Notification to Indian People of the Billings Area Policies (Bulletins) on Contract Health Services

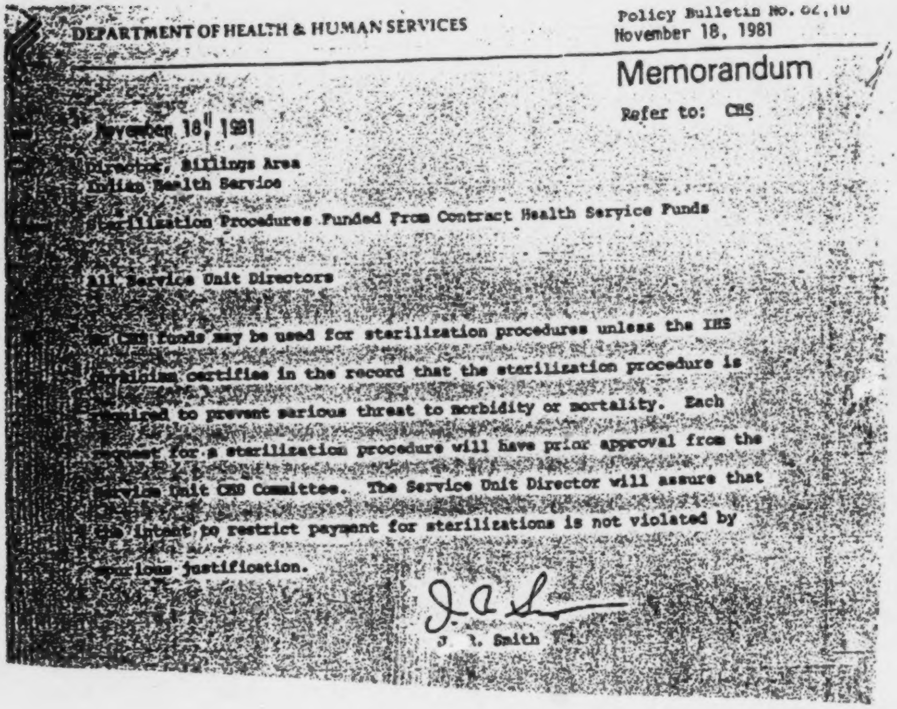
All Service Unit Directors

It is necessary that we attempt to make the Indian people we serve aware of the recent Area policies (Bulletins) on medical services available through the Contract Health Services program.

Therefore, as a minimum you are required to post these bulletins in public areas within your IHS facility and to provide copies to, and discuss the policies with, the local Tribal Health organization.

J. R. Smith

Tribal Health
Organization



DEPARTMENT OF HEALTH & HUMAN SERVICES

Policy Bulletin No. 82,10
November 18, 1981

Memorandum

Refer to: CHS

November 18, 1981

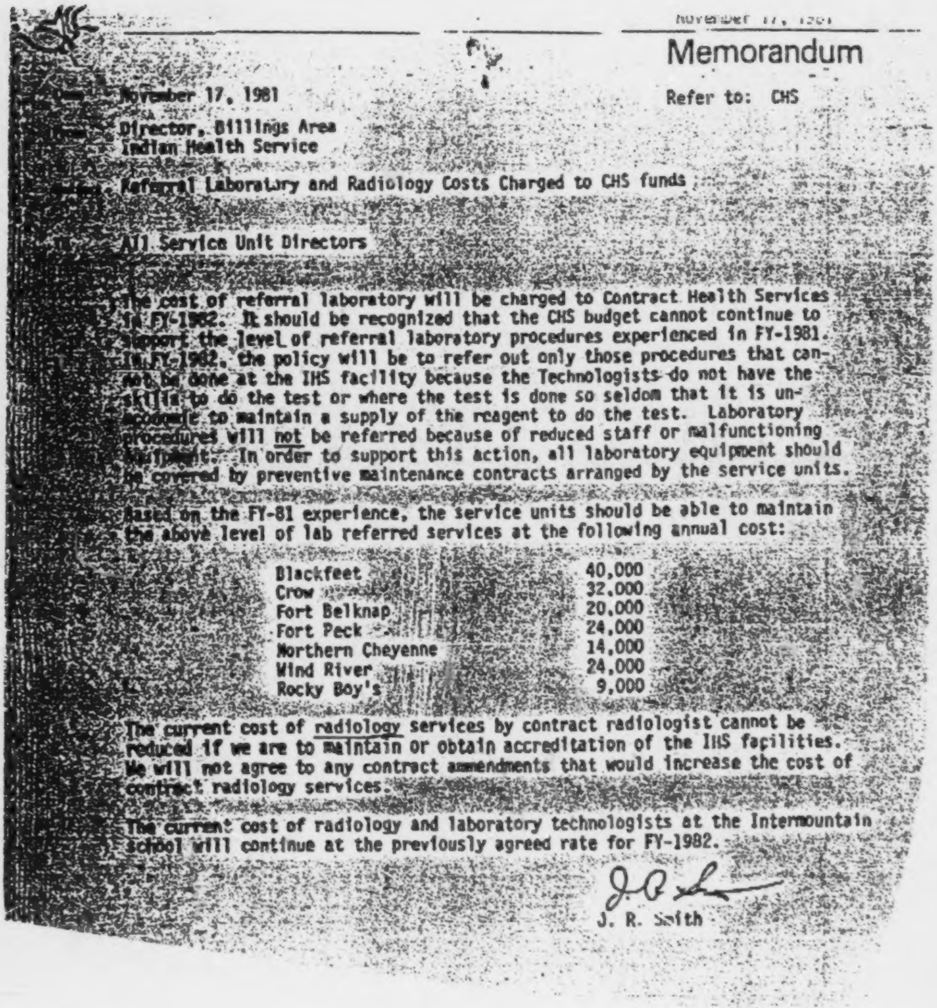
Director, Billings Area
Indian Health Service

Sterilization Procedures Funded From Contract Health Service Funds

All Service Unit Directors

No CHS funds may be used for sterilization procedures unless the IHS physician certifies in the record that the sterilization procedure is required to prevent serious threat to morbidity or mortality. Each request for a sterilization procedure will have prior approval from the Service Unit CHS Committee. The Service Unit Director will assure that the intent to restrict payment for sterilizations is not violated by spurious justification.

J. R. Smith



November 17, 1981

Memorandum

November 17, 1981

Refer to: CHS

Director, Billings Area
Indian Health Service

Referral Laboratory and Radiology Costs Charged to CHS funds

All Service Unit Directors

The cost of referral laboratory will be charged to Contract Health Services in FY-1982. It should be recognized that the CHS budget cannot continue to support the level of referral laboratory procedures experienced in FY-1981. In FY-1982, the policy will be to refer out only those procedures that cannot be done at the IHS facility because the Technologists do not have the skills to do the test or where the test is done so seldom that it is uneconomic to maintain a supply of the reagent to do the test. Laboratory procedures will not be referred because of reduced staff or malfunctioning equipment. In order to support this action, all laboratory equipment should be covered by preventive maintenance contracts arranged by the service units.

Based on the FY-81 experience, the service units should be able to maintain the above level of lab referred services at the following annual cost:

Blackfeet	40,000
Crow	32,000
Fort Belknap	20,000
Fort Peck	24,000
Northern Cheyenne	14,000
Wind River	24,000
Rocky Boy's	9,000

The current cost of radiology services by contract radiologist cannot be reduced if we are to maintain or obtain accreditation of the IHS facilities. We will not agree to any contract ammendments that would increase the cost of contract radiology services.

The current cost of radiology and laboratory technologists at the Intermountain School will continue at the previously agreed rate for FY-1982.

J. R. Smith

Billings Area IHS
Policy Bulletin No. 82.2
(3 pages)
November 10, 1981

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Refer to: CHS

Date · November 10, 1981

From Director, Billings Area
Indian Health Service

Subject Management of the Contract Health Service Program

To All Service Unit Directors

The reduction in CHS funding for FY-1982 requires that the service units have a management system that can monitor the on going activity for adherence to the CHS regulations, control expenditures, utilize alternate resource, and ensure physician involvement in the decisions being made. To achieve this, each service unit will, if not already in place, establish a CHS Committee to accomplish the above requirement. This committee shall consist of the Service Unit Director or Administrative Officer, the CHS supervisor, the social worker, and the Clinical Director or one member of the medical staff. Other members may be added, permanently or intermittently, as the Service Unit Director determines necessary. The committee shall meet at least weekly.

This committee shall review all CHS activity that has occurred during the previous week as to regulatory requirements, utilization of alternate resources, and whether services were within the Area's medical priority. The committee will also review all proposed expenditures of CHS funds on the same basis. Any emergency referrals that did not have prior review by the CHS Committee will also be reviewed to ensure that the policy on referrals was not violated.

The CHS Committee should have available at each weekly meeting, a report on each case to be discussed similar to Attachment A. Items discussed, but not resolved, should be assigned to an individual to research and report at the next weekly meeting.

The CHS Committee should also have a CHS fund report at each weekly meeting so that all members will be aware of the current situation. We recommend the following format for this report.

(1) Allowance so far this year $____________________
(2) Less balance on commitment register $____________________
(3) Total obligated so far this year (1 less 2) $____________________
(4) Less known obligations not on commitment register $____________________
(5) Spent so far this year (3 + 4) $____________________
(6) Number of weeks so far this year ____________________
(7) Average expenditure per week $____________________
(8) Surplus or (deficit) if expenditures continue at this rate
$____________________

Where:

(1) = Allowance through current quarter.
(5) = (3) plus (4)
(6) = Number of weeks since October 1st
(7) = (5) divided by (6)
(8) = (1) less product of number of weeks through the end of the quarter times (7)

Copies of the reports for each weekly meeting will be forwarded to the Area CHS Branch.

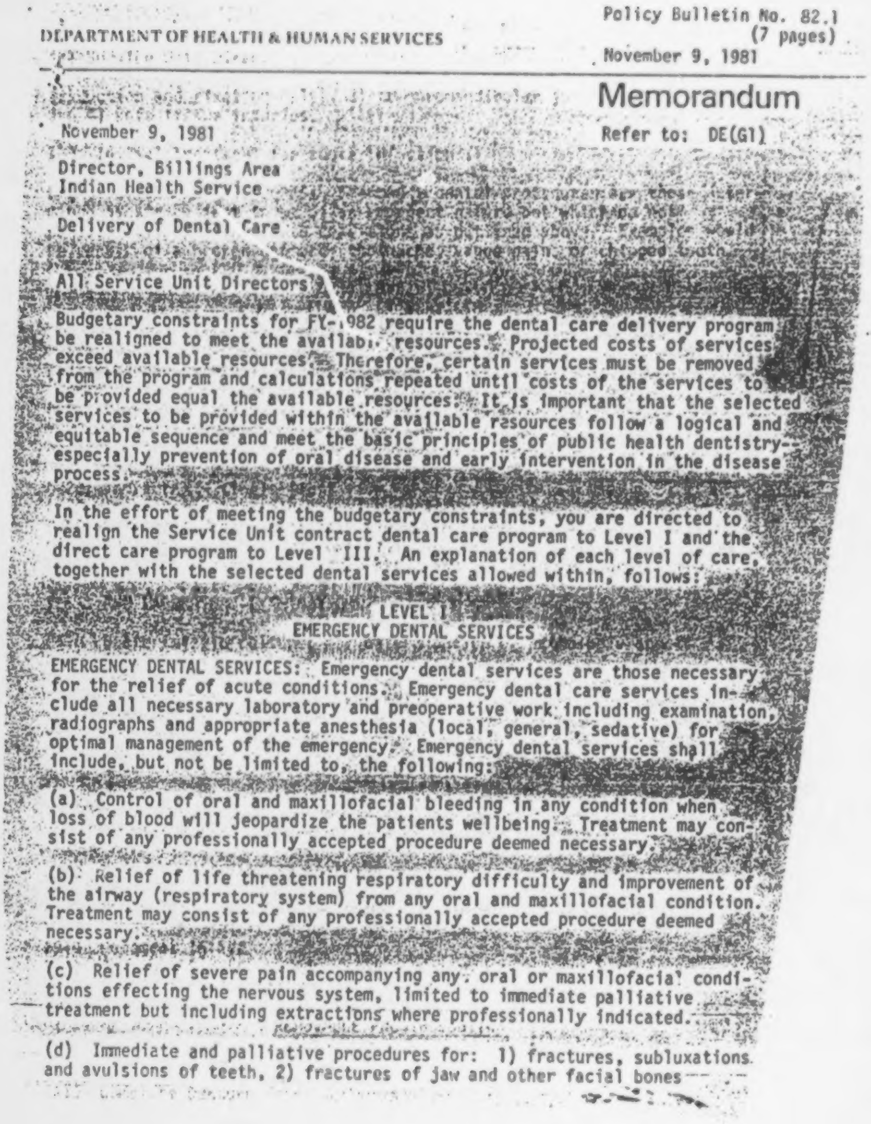
J. R. Smith

Attachment

WEEKLY REPORT DMISSIONS
TO CONTRACT HOSPITALS

For Week Ending____________________

tient Name	Date Admitted	Date Discharged	Admitting Diagnosis	Amount Obligated	Contract Hospital	Contract M.D./Primary	Alternate Resource	Actions To Be Taken



Policy Bulletin No. 82.1
(7 pages)
November 9, 1981

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

November 9, 1981

Refer to: DE(G1)

Director, Billings Area
Indian Health Service

Delivery of Dental Care

All Service Unit Directors

Budgetary constraints for FY-1982 require the dental care delivery program be realigned to meet the available resources. Projected costs of services exceed available resources. Therefore, certain services must be removed from the program and calculations repeated until costs of the services to be provided equal the available resources. It is important that the selected services to be provided within the available resources follow a logical and equitable sequence and meet the basic principles of public health dentistry--especially prevention of oral disease and early intervention in the disease process.

In the effort of meeting the budgetary constraints, you are directed to realign the Service Unit contract dental care program to Level I and the direct care program to Level III. An explanation of each level of care, together with the selected dental services allowed within, follows:

LEVEL I
EMERGENCY DENTAL SERVICES

EMERGENCY DENTAL SERVICES: Emergency dental services are those necessary for the relief of acute conditions. Emergency dental care services include all necessary laboratory and preoperative work including examination, radiographs and appropriate anesthesia (local, general, sedative) for optimal management of the emergency. Emergency dental services shall include, but not be limited to, the following:

(a) Control of oral and maxillofacial bleeding in any condition when loss of blood will jeopardize the patients wellbeing. Treatment may consist of any professionally accepted procedure deemed necessary.

(b) Relief of life threatening respiratory difficulty and improvement of the airway (respiratory system) from any oral and maxillofacial condition. Treatment may consist of any professionally accepted procedure deemed necessary.

(c) Relief of severe pain accompanying any oral or maxillofacial conditions effecting the nervous system, limited to immediate palliative treatment but including extractions where professionally indicated.

(d) Immediate and palliative procedures for: 1) fractures, subluxations and avulsions of teeth, 2) fractures of jaw and other facial bones (reduction and fixation only), 3) temporomandibular joint subluxations, and 4) soft tissue injuries.

(e) Initial treatment for acute infections.

EMERGENCY DENTAL PROCEDURES: Emergency dental procedures are those determined by the patient to be of an emergent nature but which do not necessarily represent acute conditions as outlined above. Examples would be repair of a broken denture, toothache, vague pain, or chipped tooth.

LEVEL I
EMERGENCY SERVICES

DIAGNOSTIC

CLINICAL ORAL EXAMINATIONS

0130	Emergency Oral Examination

RADIOGRAPHS

0220	Intraoral - single first film
0230	Intraoral - periapical - each additional film
0250	Extraoral - single, first film
0260	Extraoral - each additional film
0290	Posteroanterior and lateral skull and facial bone, survey film

TESTS AND LABORATORY EXAMINATIONS

0410	Bacteriologic cultures for determination of pathologic agents
0460	Pulp Vitality Tests

PREVENTIVE

SPACE MAINTAINERS

1550	Recementation of space maintainer

RESTORATIVE

CROWNS - Single Restorations

2840	Temporary (fractured tooth)

OTHER RESTORATIVE SERVICES

2910	Recement Inlays
2920	Recement Crowns
2940	Fillings (sedative)

REMOVABLE PROSTHODONTICS

ADJUSTMENTS TO DENTURES

5410	Complete Denture
5421	Partial Denture (upper)
5422	Partial Denture (lower)

REPAIRS TO DENTURES

5610 Repair broken complete or partial denture - no teeth damaged
5620 Repair broken complete or partial denture - replace one broken tooth
5630 Replace additional teeth - each tooth
5640 Replace broken tooth on denture - no other repairs
5650 Adding tooth to partial denture to replace extracted tooth - each tooth (not involving clasp or abutment tooth)
5660 Adding tooth to partial denture to replace extracted tooth - each tooth (involving clasp or abutment tooth)
5670 Reattaching damaged clasp on denture
5680 Replacing broken clasp with new clasp on denture
5690 Each additional clasp with rest

FIXED PROSTHODONTICS

REPAIRS TO BRIDGEWORK

6610 Replace broken pin facing with slotted or other facing
6620 Replace broken facing where post is intact
6630 Replace broken facing where post backing is broken
6640 Replace broken facing with acrylic
6650 Replace broken pontic

OTHER PROSTHETIC SERVICES

6930 Recement Bridge

ORAL SURGERY

EXTRACTIONS

7110 Single tooth
7120 Each additional tooth

SURGICAL EXTRACTIONS

7210 Extraction of tooth - erupted

OTHER SURGICAL PROCEDURES

7270 Tooth replantation

SURGICAL EXCISION

7425 Excision pericoronal gingiva

SURGICAL INCISION

7510 Incision and drainage of abscess - intraoral
7520 Incision and drainage of abscess - extraoral

TREATMENT OF FRACTURES - SIMPLE

7610 Maxilla - open reduction, teeth immobilized (if present)
7620 Maxilla - closed reduction, teeth immobilized (if present)
7630 Mandible - open reduction, teeth immobilized (if present)
7640 Mandible - closed reduction, teeth immobilized (if present)
7650 Malar and/or zygomatic arch - open reduction
7660 Malar and/or zygomatic arch - closed reduction
7670 Alveolus - stabilization of teeth, open reduction splinting
7680 Facial bones - complicated reduction with fixation and multiple surgical approaches

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

7820 Closed reduction of dislocation
7830 Manipulation under anesthesia

REPAIR OF TRAUMATIC WOUNDS

7910 Suture of recent small wounds up to 5cm

COMPLICATED SUTURING (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)

7911 Up to 5cm
7912 Over 5cm

OTHER REPAIR PROCEDURES

7990 Emergency tracheotomy

ADJUNCTIVE GENERAL SERVICES

UNCLASSIFIED TREATMENT

9110 Palliative (emergency) treatment of dental pain, minor procedures
Examples: Trauma to a tooth, sinus pain mimicking toothache, periodontal abscess, acute necrotizing ulcerative gingivitis, etc.

PROFESSIONAL VISITS

9440 Office visit - after regularly scheduled office hours

DRUGS

9610 Therapeutic drug injection (by report)
9630 Other drugs and/or medicaments (by report)

MISCELLANEOUS

9910 Application of desensitizing medicaments
9930 Complications (postsurgical - unusual circumstances) (by report)
9999 Unspecified (by report to be described by statement of attending dentist)

LEVEL III
SECONDARY DENTAL CARE

DIAGNOSTIC

Secondary dental care services are those provided early and which contain the disease process once it has begun. Dental disease process progresses on a continuum from microscopic lesion, to barely perceptible by radiographic or visual observation, to obvious disease, to involvement requiring surgical removal or intervention. Secondary dental care services would be provided at the barely perceptible to obvious disease categories on this continuum.

CLINICAL ORAL EXAMINATIONS

0110	Initial Oral Examination
0120	Periodic Oral Examination

RADIOGRAPHS

0210	Intraoral - complete series (including bitewings)
0240	Intraoral - occlusal film
0270	Bitewings - single film
0272	Bitewings - two films
0273	Bitewings - three films
0274	Bitewings - four films
0330	Panoramic - maxilla and mandible film

TESTS AND LABORATORY EXAMINATIONS

0450	Histopathologic examination
0470	Diagnostic Casts

PREVENTIVE

SPACE MAINTAINERS

1510	Fixed - unilateral type
1515	Fixed - bilateral type
1525	Removable bilateral type

RESTORATIVE

AMALGAM RESTORATIONS (including polishing)

2110	Amalgam - one surface deciduous
2120	Amalgam - two surfaces, deciduous
2130	Amalgam - three surfaces, deciduous
2140	Amalgam - one surface, permanent
2150	Amalgam - two surfaces, permanent
2160	Amalgam - three surfaces, permanent

ACRYLIC OR PLASTIC RESTORATIONS

2330 Composite resin, (Class III or V)
2335 Composite resin, (Class IV)

CROWNS - Single Restorations

2710 Plastic (acrylic)
2711 Plastic - prefabricated
2830 Stainless Steel

ENDODONTICS

PULPOTOMY

3220 Vital Pulpotomy/Pulpectomy in primary teeth (excluding final restoration)

ROOT CANAL THERAPY (excludes final restoration)

3310 Anterior Tooth
3350 Apexification

PERIODONTICS

ADJUNCTIVE PERIODONTAL SERVICES

4340 Periodontal Scaling and root planing (entire mouth)
4341 Periodontal Scaling (fewer than 12 teeth)

PROSTHODONTICS

DENTURE RELINING

5850 Tissue Conditioning

ORAL SURGERY

OTHER SURGICAL PROCEDURES

7285 Biopsy of oral tissue (hard)
7286 Biopsy of oral tissue (soft)

SURGICAL EXCISION

7410 Radical excision - lesion diameter up to 1.25 cm
7420 Radical excision - lesion diameter over 1.25 cm
7430 Excision of benign tumor - lesion diameter up to 1.25 cm
7431 Excision of benign tumor - lesion diameter over 1.25 cm
7440 Excision of malignant tumor - lesion diameter up to 1.25 cm
7441 Excision of malignant tumor - lesion diameter over 1.25 cm
7450 Removal of odontogenic cyst or tumor - up to 1.25 cm in diameter
7451 Removal of odontogenic cyst or tumor - over 1.25 cm in diameter
7460 Removal of nonodontogenic cyst or tumor - up to 1.25 cm in diameter
7461 Removal of nonodontogenic cyst or tumor - over 1.25 cm in diameter
7465 Destruction of lesions by physical methods: electrosurgery, chemotherapy, cryotherapy

DEPARTMENT OF HEALTH & HUMAN SERVICES

Policy Bulletin No. 82.6
November 16, 1981

Memorandum

Refer to: CHS

November 16, 1981

Director, Billings Area
Indian Health Service

Patient and Patient Escort Travel

All Service Unit Directors

Contract Health Services may be used for patient and patient escort travel with the following limitations.

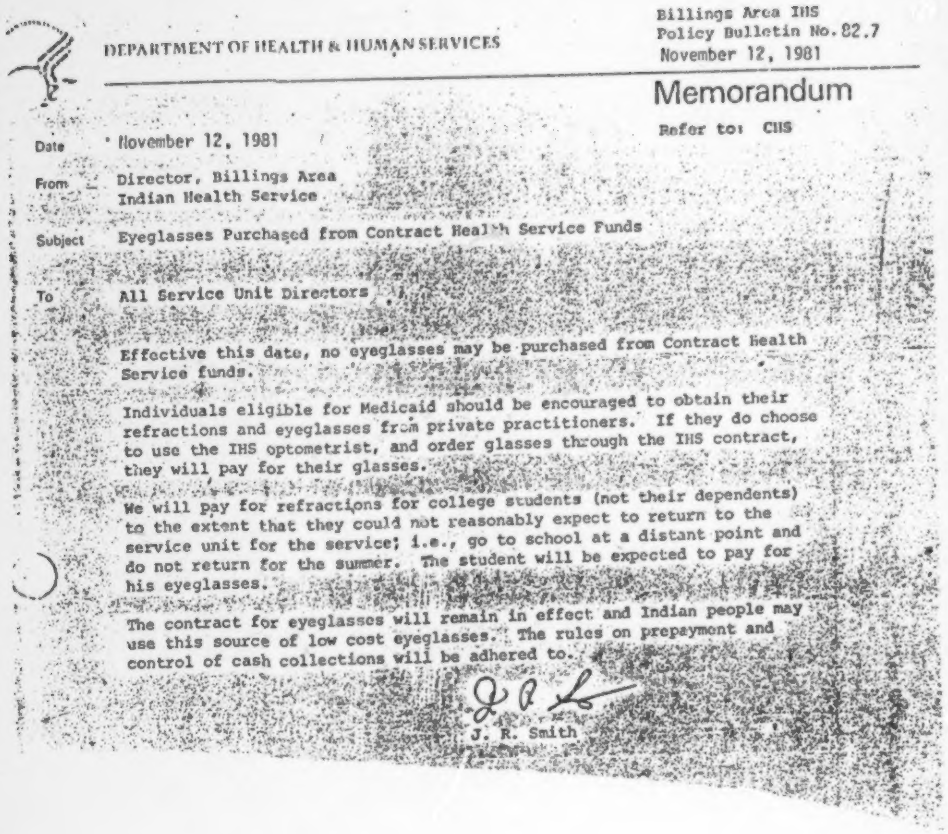
Patient travel - IHS personnel and vehicles or tribal contract personnel with responsibilities under their contract to provide transportation for patients should be the primary source of transportation of patients within the confines of the State. Transportation of patients is not a right and should not be authorized at the expense of CHS funds if the individual is able to provide his/her own transportation. CHS funds may be used for patient travel when there is no other alternative. The most economical source of common carrier that provides a reasonable schedule will be utilized.

Patient escort - CHS funds may be used to furnish one escort to a child (eighteen and under) or to an adult who has a handicapping condition that precludes his traveling unassisted. Costs will be limited to the most economical common carrier plus a reasonable amount of funds for food and lodging. We suggest arrangements be made, whenever possible, to utilize low cost lodging and meals that are sometimes available around hospitals and are known to the social service department of the hospital.

The intent of this policy is to limit payment of patient and patient escort costs to the lowest level commensurate with the requirement that an individual not be denied an emergency service because he/she cannot afford the travel costs or cannot travel alone.

The payment of ambulance costs related to treatment of an emergency condition is a permissible charge to CHS.

J. R. Smith



Billings Area IHS
Policy Bulletin No. 82.7
November 12, 1981

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Refer to: CHS

Date November 12, 1981

From Director, Billings Area
Indian Health Service

Subject Eyeglasses Purchased from Contract Health Service Funds

To All Service Unit Directors

Effective this date, no eyeglasses may be purchased from Contract Health Service funds.

Individuals eligible for Medicaid should be encouraged to obtain their refractions and eyeglasses from private practitioners. If they do choose to use the IHS optometrist, and order glasses through the IHS contract, they will pay for their glasses.

We will pay for refractions for college students (not their dependents) to the extent that they could not reasonably expect to return to the service unit for the service; i.e., go to school at a distant point and do not return for the summer. The student will be expected to pay for his eyeglasses.

The contract for eyeglasses will remain in effect and Indian people may use this source of low cost eyeglasses. The rules on prepayment and control of cash collections will be adhered to.

J. R. Smith

DEPARTMENT OF HEALTH & HUMAN SERVICES

Billings Area IHS
Policy Bulletin No. 82,5
(3 pages)
November 12, 1981

Memorandum

Refer to: CHS

Date November 12, 1981

From Director, Billings Area
Indian Health Service

Subject Mental Health Services Funded from Contract Health Services

To All Service Unit Directors

The enclosed "Contract Health Service Policy for Mental Health" provides guidance in establishing priorities for the expenditures of CHS funds for mental health services.

Priority 1 services are considered medical emergencies and may be authorized for payment. Priority 2 and 3 services may be authorized for payment after review of the case by the Area Mental Health Consultants.

Normal review to ensure that all regulatory requirements are met is mandatory.

J. R. Smith

Attachment

CONTRACT HEALTH SERVICE POLICY FOR MENTAL HEALTH

Note: Prior to authorization of contract services for these patients, it is required that local treatment and diagnostic resources be exhausted. Basic mental status, suicide/homicide and neurological examinations must be carried out as appropriate prior to referral. Similarly, outpatient and short term treatment remedies should be exhausted prior to initiating contract referral. Use of Area Consultants for diagnostic and treatment technology is strongly recommended. Priority I patients are considered medical emergencies. Priority II and III patients must be reviewed with Area Consultants before contract care is authorized.

Note: See Area Mental Health Policy and Procedure Manual for evaluation guidelines.

Note: Priority 1 - Inpatient Care required
Priority 2 - Inpatient or Outpatient
Priority 3 - Inpatient (rarely), Outpatient (usually)

Prioritization of Mental Health Contract Services:

Priority 1 - Immediately life threatening conditions. These generally require constant care from the moment of presentation.

A. Psychoses with an acute course including: psychotic organic mental syndromes such as delerium tremens, post traumatic encephalopathies, viral syndromes, etc. (300 + individual causes known); acute schizophrenic episodes; psychoses associated with depression and mania; acute psychoses with unknown etiology. Psychoses are defined as conditions with hallucinations and/or delusions.

B. Organic mental syndromes with an acute, diagnosed or undiagnosed course. From infections, toxic, traumatic, endocrine, metabolic, certain vitamin deficiencies, vascular, neoplastic or autoimmune, drug or alcohol etiologies.

C. Patients immediately dangerous to others including acutely paranoid, psychotic, organic, or decompensated character-disordered patients and patient with clearly expressed violent or homicidal ideation.

D. Suicidal patients with high-lethality suicide attempts, high lethality ideation and method or high risk-factor profile and intermediate lethality potential.

E. Uncommunicative patients with history or actions suggestive of organic mental syndrome or acutely psychotic course.

Note: Absence of diagnostic clarity resulting from lack of appropriate diagnostic evaluation is not an acceptable substitute for appropriate diagnostic procedures carried out at the service unit.

Priority 2 - Conditions likely to be life threatening on a less acute basis. Defined as a reasonable probability of loss of life within one month if untreated.

A. Organic mental syndromes of an undiagnosed etiology, but chronic course. Organic mental syndromes of diagnosed etiology, chronic course with available interventions (e.g., viral, tuberculous, metabolic, autoimmune, etc.)

B. Anorexia nervosa, bulemia and chronic life threatening eating disorders.

C. Organic mental syndromes and psychoses that render patient incapable of caring for basic needs (e.g., patient may wander into traffic, set house on fire, starve to death, etc.) Found in patients lacking local support network.

D. Depressive illness with steady downhill course. (Depression here is defined as both primary or secondary, but with biological symptoms of sleep disorder, weight loss, appetite disturbance, etc.)

E. Victims of spouse or child abuse.

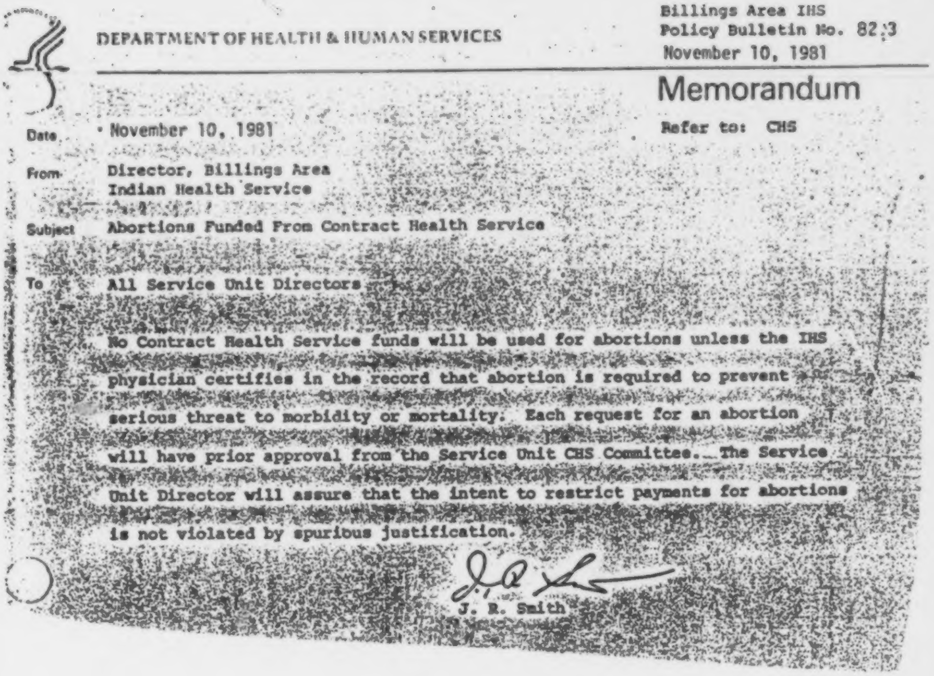
Priority 3 - Conditions with an increased death rate, but without an immediately threatening course, or dangerous conditions for which no effective treatment is available.

A. Borderline State

B. Factitious Disorders

C. Severe Obsessive States

D. Sleep Disorders with suspicion of an apnea component.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Billings Area IHS
Policy Bulletin No. 82-3
November 10, 1981

Memorandum

Refer to: CHS

Date November 10, 1981

From Director, Billings Area
Indian Health Service

Subject Abortions Funded From Contract Health Service

To All Service Unit Directors

No Contract Health Service funds will be used for abortions unless the IHS physician certifies in the record that abortion is required to prevent serious threat to morbidity or mortality. Each request for an abortion will have prior approval from the Service Unit CHS Committee. The Service Unit Director will assure that the intent to restrict payments for abortions is not violated by spurious justification.

J. R. Smith

Senator MELCHER. John Houle, Rocky Boy.

STATEMENT OF JOHN HOULE, CHAIRMAN, ROCKY BOY HEALTH BOARD, BOX ELDER, MONT.

Mr. HOULE. Thank you, Senator. I am chairman of the Health Board at Rocky Boy. We have five areas of concern. The first one, I think, is, we are worried about the elimination of the community health representative program. This, you know, is a program that has really helped out our elders, the senior citizens, who are really in need of this type of service.

To us, you know, the CHR program is not a make-work program; it is something that helps our community.

And our second issue was with the Public Law 86–121 funds being frozen at this time. They were appropriated for the purpose of——

Senator MELCHER. Can you speak a little bit louder, John?

Mr. HOULE. The Public Law 86–121 moneys were appropriated to provide water and sewer to the HUD housing, and now they are being frozen. We have housing projects on the reservation that do not have water in them, and it is really creating a lot of problems.

Our third concern is with the alcoholism program. It is a much needed program on the reservation as, I guess, with any other reservation. It creates all kinds of social and health problems.

Our last point would be the reduction of funds for our contract health care. At this point, we are without funds for contract health care, and it is really creating a problem at our service unit.

So, with that, I would like to thank you.

Senator MELCHER. When did you last have contract health funds?

Mr. HOULE. Well, we had some left over, I guess it was within the last—maybe possibly the last month.

Senator MELCHER. You ran out in the last month?

Mr. HOULE. Yes.

Senator MELCHER. Thank you very much.

Will anyone be here this afternoon for Rocky Boy housing?

Mr. HOULE. Yes.

Senator MELCHER. Clayton Small.

STATEMENT OF CLAYTON SMALL, EXECUTIVE DIRECTOR, INTER-TRIBAL POLICY BOARD, BILLINGS, MONT.

Mr. SMALL. Thank you, Senator Melcher. I am here in behalf of the Montana Inter-Tribal Policy Board, the Indian organization which represents the eight tribal governments in Montana. In behalf of the policy board, we would like to thank the select committee for conducting this oversight hearing on IHS and Indian housing.

I would like to summarize our report and footnote that we have additional documentation that will clarify some of the points that we would like to make in summary.

The IHS reports that alcohol use and abuse is the most widespread and severe health problem within the American Indian communities. IHS further reports that 5 of the top 10 causes of death among Indians are directly related to alcohol. They are: (1) accidents, (2) cirrhosis of the liver, (3) alcoholism, (4) suicide, and (5) homicide. Social conditions such as unemployment, inferior education, discrimination, acculturation, poor health and isolation also promote Indian alcoholism. Validated research asserts that people with a stake in society will be less likely to exhibit deviant behavior than those who do not. The majority of Indian people are disillusioned, angered, and frustrated with their investments to our society not deriving benefits to them. The result is Indian alcoholism being our No. 1 killer! In 1980, the NCAI adopted a "Declaration of War" on alcoholism and drug abuse and in 1981, NCAI adopted a position to seek funding and assistance from the World Health Organization in Geneva, Switzerland. In the era where self-determination is the operative policy and the political, social, and economic well-being of the American Indian people is the responsibility of the tribal governments, we see the tribal leadership asserting their authority to make self-sufficiency a reality. To make this work, however, we need cooperation, commitment, and dedication from IHS through their trust responsibility to assist tribal leadership. The central and area IHS offices have failed to uphold their responsibilities and with this in mind, the MITPB recommends that the U.S. Senate Select Committee thoroughly investigate the following concerns:

No. 1, the December 4, 1981, firing of the Billings area alcoholism coordinator. Ms. Cantarella was terminated for doing her job with dedication and serving as an advocate for tribes. She was told not to do anything for 1 year until her probation ended. She received no support from her superiors for advocating improved health care.

No. 2, confirmation by Billings Area Office IHS administration to continue the area alcoholism component and recruit and hire immediately.

No. 3, contractual irregularities by Billings Area IHS administration and spending alcoholism moneys to serve nonalcohol related activities at Brigham City service unit.

No. 4, failure of Billings Area IHS Office administration to respond to tribal and Indian organization resolutions.

No. 5, lack of Billings Area Office IHS establishing a formal consultations process with tribal leadership. Examples include: (a) future direction and priorities for IHS; (b) trust responsibility being extinguished by IHS for delivery of contract care to tribes; (c) direct funding to tribes such as medicare/medicaid; and (d) legislation to establish line item for alcoholism.

No. 6, lack of technical assistance and training provided by IHS to tribal health boards and program personnel. A prime example is the lack of technical assistance provided to tribal health boards to assist them to increase their capability to provide for a continuum of care.

No. 7, why does the Billings area office IHS have two area mental health consultants—GS-13 and 14—with a combined salary of over $70,000 per year plus travel expenses? This alludes to IHS administration establishing priorities to mental health rather than tribal declared priorities; that is, alcoholism. The approach used by mental health consultants needs to be investigated in terms of Indian people who deviate from the world's madness and are being given fraudulent diagnostic tests which generate diagnostic labels, which lead to treatment, which is in fact a series of graded repressive procedures such as drug management, hospitalization, shock therapy, and perhaps lobotomy.

No. 8, the problems relating to the IHS Billings area office are directly attributed to management and leadership. Improved health care for tribes will remain unstable until there is a personnel change in upper management of the area office. For example, there is not a team interdisciplinary approach to health care problems. This has resulted in a serious lack of morale at the BAO IHS office. It has further resulted in unethical personnel practices and internal conflicts which does not benefit the public which IHS serves.

Thank you.

Senator MELCHER. Thank you very much, Clayton. That concludes the panel.

STATEMENT OF GREG DuMONTIER, DIRECTOR, FLATHEAD TRIBAL HEALTH DEPARTMENT, ST. IGNATIUS, MONT.

Mr. DUMONTIER. Thank you, Senator. I appreciate the opportunity to express the following concerns on behalf of the Confederated Salish and Kootenai Tribes regarding the impact of funding reductions on both Indian Health Service and Tribal Health Department functions.

The Tribal Health Board and Department, which functions primarily on grant funds allocated through Public Law 93–638, has been developing steadily since 1977. We are presently on the threshold of an exciting and challenging future as we have just recently passed a duly authorized resolution and supporting letter of intent to fully implement self-determination by contracting all Indian Health Service functions within the next 2 fiscal years. This action represents a commitment to our beliefs that local control of health programs and policies will provide for higher quality cost effective health services most appropriate to the specific health problems of our people.

However, recent reductions in self-determination funding may prevent our tribes from taking the final and culminative step of a process involving 4½ years of Federal funding and tribal effort. This situation is indeed a tragedy for those who have labored so diligently in the name of self-determination as well as an abandonment of a substantial investment of Federal funding. While it can be understood that the Federal Government is driven by an overriding need to contain the cost of its programs, it is difficult to comprehend the rationale which allows the administration of the Indian Health Service to continue its relatively high level of operation while reservation health services and tribal efforts to improve the quality and cost effectiveness of those services bear the brunt of cost control measures. What is clearly called for is a reassessment of those actions which have apparently altered the original Federal commitment to self-determination.

Self-determination, when implemented in a cooperative fashion between the Federal Government and tribal governments, represents the best hope for providing health care in accordance with treaty obligations in the most cost-effective manner.

I respectively submit to you that when dealing with reductions in Indian Health Service funded and operated programs, the question is not so much which programs can be reduced with minimal impact, but how reductions should be applied with respect to the reservation health care delivery system as a whole. The impact of reducing a health program on an IHS-wide basis will vary from reservation level in a similar way that States are allowed to make reductions under the block grant concept. Each tribe would then have the opportunity to decide how to distribute funding reductions among their own IHS or tribal programs in order to minimize the impact on their reservation delivery system as a whole.

It has been nearly 7 years since the passage of the Self-Determination Act. As the ability of tribes to make their own decisions regarding their health care increases each year, there must be a corresponding decrease in policymaking authority and subsequent decreased funding allocated to the centralized administration of the Indian Health Service. The fiscal year 1982 budget for the Indian Health Service needs to reflect these changing times.

Senator MELCHER. Thank you. Cathi.

STATEMENT OF CATHI DUPUIS SHORTMAN, DIRECTOR, FLATHEAD ALCOHOLISM PROGRAM, RONAN, MONT.

Ms. SHORTMAN. I thank you very much for this opportunity to express my concerns. My primary concern is with alcoholism funding. I feel that it is strange, at best, that the level of alcoholism funding does not reflect the similar level of the problem as it is in Indian Health Services. My primary wish is to ask the Senate committee to seek line item budget funding for alcoholism at the national level. I feel that alcoholism must be a priority in Indian Health Services, since it is the No. 1 factor in the primary health problems of Indian people.

I also wish to express concern as to the elimination of the area alcoholism coordinator, Delores Cantarella. Our program at the Flathead Reservation received very strong help from Mrs. Cantarella, and I feel her termination was unjust and certainly counterproductive to the development of our alcoholism services on the Flathead Reservation.

Senator MELCHER. Do you think alcoholism is the No. 1 health problem?

Ms. SHORTMAN. Yes: I do.

Senator MELCHER. Clayton Small testified on behalf of the Inter-Tribal Policy Board, and we are just reviewing his testimony again. Do you think it ought to be a line item then?

Ms. SHORTMAN. Yes, I do.

Senator MELCHER. Set aside?

Ms. SHORTMAN. And protected as moneys for alcoholism treatment. I have no proof, but I understand that moneys set aside supposedly for alcoholism have been used for other purposes.

Senator MELCHER. Thank you very much, Cathi.

Who is next?

Minnie Ellen Fritzler, speaking for the Crow. I guess you will be next.

STATEMENT OF MINNIE ELLEN FRITZLER, CROW TRIBAL ADMINISTRATION, CROW AGENCY, MONT.

Ms. Fritzler. I have some general statements to make on behalf of the Crow Tribal Administration. We have considered the range of services provided by Indian Health Service and the relative importance of each component. Most obvious is that we cannot reduce direct patient care. One must look then to those services which are not vital to maintain life.

The contract health care program is one that is always anemic. It is the function that provides care beyond the scope of our local Indian Health Service facility.

Currently only life-saving situations are being referred out, so cases such as one who needs diagnostic service to determine the cause of chest pain and one who needs a comminuted fracture set cannot be referred because these are not life-threatening situations.

This service is not only indispensable; it simply is not meeting our health needs and should be augmented. Perhaps health insurance should be considered here. Most definitely, alternative coverage must be determined and used.

Dental care—the lack of dental services would pose no threat to life, but good dentition is vital to good health. Preschoolers with dental caries soon develop into young adults, either toothless or draining poison from rotting teeth into their bodies. We need dental care.

Optometry—poor vision is no threat to life, but faulty vision in would-be workers would even be more damaging to a dismal employment potential on the reservation.

Education is difficult to obtain if one cannot see to learn to read. We need optometric care.

Mental health and social services are not vital to maintain life. It is recognized that stress is closely related to illness. Indian reservations are subject to much stress illness: Alcoholism and all the resultant mental and emotional trauma, unemployment, various forms of racial discrimination, all contribute to tragic human situations, which affect the life and health of individuals and families. These services provide a much-needed support system.

Environmental and sanitation services.—One might find it difficult to relate these services to life and limb, but the first outbreak of epidemic disease would soon prove that expertise is necessary to deal with an epidemic situation.

The range of services provided: Indoor sanitary facilities, potable water supplies, sewage and refuse disposal, rabies surveillance, all control the spread of disease and are vital to the health of the Crow Reservation population.

Field Health Services.—This is the team that provides preventive services to schoolchildren and the homebound as well as the general population. Much of the educational effort to teach the principles of keeping well are provided individually and collectively by field health staff. This is a very important segment of the health program. Like the rest of the Nation, we must turn around the situation of caring for bodies which have broken down in some area and trying to repair damage after it is done. Health services must begin to address the issue of how to stay well.

Before the advent of so-called modern medicine to Indian country, the people enjoyed a superior level of health. It was only with the arrival of civilization that we began to experience such maladies as tuberculosis, diabetes, heart disease, cancer, and alcoholism. I believe if we look back and examine the lifestyle of our people when they were vigorous, strong, and healthy; how they lived, what they ate, what stresses they were subject to, we could learn a great deal and possibly even achieve that turn-around.

This is an area that needs even more development in order to promote a higher level of health among our people.

The CHR program was conceived to function as an extension of the Indian Health Service program; a program that could do some things beyond the restrictions of Government-operated health program; a liaison between IHS and the people; a paraprofessional group who could function from their background as native people in the health care program.

This and the health board concept are the means by which we have some input into the health service program. This function is also the means by which we may be beginning to achieve some self-sufficiency in our own health care. It is our understanding that self-determination is the operative policy of the day. That being so, these two functions will prove vital in the uncertain times ahead.

As to the question of allocation of cuts between administration and direct services, it should go without saying that administration would have nothing to administer without direct services. Perhaps the time is now to decentralize area functions to the local level.

In summary, then, we find the health services being provided are all vitally necessary to meet the health needs of our people. No segment of the program can be reduced without serious impact. Not only are we unable to say we can survive without this service or that we strongly feel that it is an obligation of the U.S. Government, though its treaties with Indian nations and later affirmed by the Snyder Act, to provide health care. We cannot stress this responsibility strongly enough. This fact alone should justify funding of health care to Indian tribes aside from the regular budgetary process and be treated as a separate appropriation.

I thank you for your attention.

Senator **Melcher**. Thank you. David Means, director of Northern Cheyenne Health Department.

STATEMENT OF DAVID MEANS, DIRECTOR, NORTHERN CHEYENNE TRIBAL DEPARTMENT, LAME DEER, MONT.

Mr. **Means**. I would like to thank Senator Melcher for allowing the Northern Cheyenne Tribe to testify. At this time it is very hard for the Northern Cheyenne Tribe to testify on specific impacts on the funding restrictions on health care programs. But as stated by other people's testimony, there has been impacts in the CHR, contract health services program, dental programs, alcoholism, et cetera, and at this time I would just like to present written testimony to the committee.

Senator **Melcher**. Thank you for the material. It will be made a part of the record at this point.

[The material follows. Testimony resumes on p. 119.]

NORTHERN CHEYENNE
COMMUNITY HEALTH REPRESENTATIVE
P. O. BOX 376 PHONE (406) 477-6322
LAME DEER, MONTANA 59043

December 18, 1981

TO WHOM IT MAY CONCERN:

The Northern Cheyenne Community Health Representatives feel that the budget cuts would definitely have an impact on the services we provide to the people on the Northern Cheyenne Reservation.

The people out in the rural areas would not get seen. The elderly would not be provided personal care. The chronically ill would not get the personal care and follow-up that they need.

The Special Clinics we have in the community would also have an affect. Hypertension patients would not be monitored, Well Child Clinics would not have enough staff as a CHR assists in those clinics, The Diabetic Clinic would not function properly. Because of the preparation of the food is taken care of by a CHR. Appointments to the Diabetic Clinic are handled by a CHR. Transportation and interpretation is also taken care of by a CHR. The ENT Clinic would also have its draw backs. The CHR who works in that area handles all the appointments, assisting of all hearing aide users and follow-up on surgery patients. The Eye Glass program would not function without the Optometic Aides provided by CHR manpower. All procedures connected with eye glasses would be hindered. About 45% of the people if not more utilize these services provided by a CHR.

The amount of services that a CHR provides in the prevention of illnesses is approximately forty five per cent. The budget cuts would reduce this to about twenty five percent if not more. This would in turn result in more out patient clinic visits and in all probability more hospitalizations for the people on the Northern Cheyenne Reservation. The Indian Health Service is saving dollars triple to that amount it uses to fund CHR Programs.

Your consideration and understanding in behalf of the Northern Cheyenne Community Health Represenative Program would be most kindly appreciated.

NORTHERN CHEYENNE COMMUNITY HEALTH REPRESENTATIVE
STAFF

Oversight Hearings on IHS
Senate Select Committee on
Indian Affairs
Billings, Montana
December 21, 1981

Testimony of the Northern Cheyenne Tribe

My name is David Means, Director, Northern Cheyenne Tribal Health Department, Lame Deer, Montana. I am testifying on behalf of the Northern Cheyenne Tribe. I would like to thank the Honorable Senator John Melcher, for the invitation to testify before this committee.

The reason for providing testimony today, is to present to you the concerns and the problems the Northern Cheyenne Tribe forsees due to funding restrictions for Health Care Programs within the IHS and Tribal Health Care Systems.

At this time it is very hard to project specific impacts of funding restrictions on Health Care Programs. It is our opinion that we will not see the full impacts for several years in the future. Any time funding is restricted for programs that have developed over several years the quality and quantity of these programs will be affected. In the Area of Health Care these restrictions will result in higher costs both financial and human. A reduction in funding levels for Indian Health Service and Tribal Programs has affected the Northern Cheyenne Tribe in many ways. At this time the Northern Cheyenne Tribe would like to present several programs that have been reduced and their projected impacts.

1. CHR Program

The Community Health Representative Program was created in 1968 to meet specific needs then identified by the IHS staff as not being addressed; and to create a viable liaison between non-Indian professional staff and the Indian population. Such liaison was designed to improve communications between providers and consumers of services. As the program evolved through the years, more specific CHR training provided personnel to provide services in Specific Health related programs such as: Kidney dialysis technicians, dental assistance services, diabetic programs, optemetric programs, monitoring of patient compliance to Medical treatment plans, EMS and other programs which were not provided directly by Indian Health Service. The worth of the program is shown by a comparison of FY 80's statistics with FY 69. There was an increase of out patient visits, direct patient admissions and decrease in hospital days. For FY 80 as opposed to FY 69 these statistics were derived from Indian Health Service, Billings Area Office, showing the effectiveness of the CHR Program as a preventive Health Care Program. CHR's by being liaisons between Indian Communities and Health providers, were able to bring the patients into the Health Delivery System before illness' became acute, thus eliminating extended stays in the hospital and providing substantial savings in CHS Funds. A reduction or elimination of the CHR program would have long range impacts to those chronically ill who would not get personal care and follow up services that they need and to those patients who need special clinics in order to overcome their medical programs resulting in higher medical costs for hospitalization. It is the recommendation of the Northern Cheyenne Tribe that the CHR Program continue without any reductions in funding.

2. CHS Program

Contract Health Services have been reduced in the following ways:

1. Emergencies only are authorized for payment
2. No unmet surgery funds are available therefore the patients problem must be let go until it becomes acute and/or a emergency before it is authorized

This brings up a major point as to the increase of financial and human costs for surgical funding. There are many medical problems in which at the outset are not an emergent situation but because of lack of contract health dollars to take care of the problem in the beginning the problem develops into an acute stage and requires more extensive intervention resulting in higher medical care. For example: Valvular Heart Disease Mitral Stenosis. If this condition is continued to let go and heart failure occurs, doing surgery then would have best arrested deterioration but the patient in all likelihood would not regain lost ground leaving the person a cardiac cripple, expensive to maintain and a risk for complications requiring expensive in-patient treatment and the possibility of living on disability payments for the rest of their life. Reductions in CHS Funds will impact patient care by delaying possible life saving medical treatment and may possibly have the adverse financial effect by increasing medical care costs for acute illness that could have been eliminated if treated earlier.

Other effects funding reductions in CHS have been implemented by IHS Billings Area Office through the following IHS Policy Bulletins:

1. 81.1 dated 11-09-81 restricted delivery of dental care and as the Dental Officer of the Northern Cheyenne Service Unit stated that this directive pretty much eliminated 50-60 percent of the services actual performed at the Northern Cheyenne Dental Clinic. It eliminated several things, large fillings, root canals, dentures full and upper, partial dentures, eleminated gum surgery, bone surgery, gold fillings, bridges, crowns, caps, impacted extractions, certain x-ray films, complicated root canals, complicated tooth or root removal, braces, fluoride treatment and certain white fillings for the front teeth.
2. 82.3 dated 11-10-81 eliminated abortions funding from Contract Health Service except those that would effect the morbidity mortality of a patient.
3. 82.4 dated 11-10-81 restricted the delivery of Mental Health Care.
4. 82.7 dated 11-12-81 restricted eye glasses purchases from Contract Health Care
5. 82.8 dated 11-15-81 restricted patient and patient escort travel.
6. 82.9 dated 11-17-81 restricted referral and laboratory and radiology
7. 82.10 dated 11-18-81 restricted sterilization procedures funded from CHS funds.

On November 17, 1981, a draft Billings Area IHS Policy Bulletin was sent to the Service Units for their review and comments. This draft policy bulletin would have affected the Northern Cheyenne Indian Health Service Unit by directing them to refer more Northern Cheyenne Patients to the Indian Health Service Crow Hospital and less to contract hospitals. The rational was that in FY 76, 29 percent of patients were sent to contract hospitals and in FY 81, 41 percent of the patients were sent to contract hospitals which as an increase of 41 percent over FY 76. The recommendation was 70 percent of the patients be referred to Indian Health Service Hospitals and 30 percent to contract hospitals.

The policy also stated that CHS budget projection for Blackfeet, Crow, Fort Belknap and Northern Cheyenne will be based on the assumption that 30 percent of the total inpatient census will be in contract hospitals and 70 percent in IHS hospitals. It also stated in recognition of the fact that the Northern Cheyenne Service Unit does not have control over who is admitted to the Crow Hospital and who is referred to Contract facilities, the Indian Health Service Billings Area Office would include in the Crow projected CHS budget funds for the contract hospitalization costs for Indians from Crow and Northern Cheyenne.

The CHS staff from Crow Service Unit will be responsible for determining the status of CHS eligibility for Northern Cheyenne patients who are referred to a contract hospital with respect to compliance with CHS regulations policy. On 11-17-81 a meeting was set at Crow hospital between the Crow Service Unit and the Northern Cheyenne Service Unit on 11-19-81. The memo was to have comments sent back to the Billings Area Office Indian Health Service no later than Thursday, 11-19-81. The Tribal Health Director was advised of the meeting by the Service Unit Director. I did attend the meeting and the implications of that meeting in my opinion, were that, CHS in-patient funding was to be transfered to Crow Service Unit CHS program along with the possibility of a position and that Crow Hospital CHS personnel would decide who would be eligible to be referred to contract facilities, eliminating much of the decisions for the Northern Cheyenne Service Unit Physicians and CHS personnel. The Northern Cheyenne Board of Health, went on record as to opposing this move. I then contacted the Tribal Chairman who the following morning of 11-20-81 contacted the Area Director and advised him of the Northern Cheyenne Board of Health resolution opposing this policy. On the morning of the 20th, I was advised by the Service Unit Director that the Area Director had contacted him and was very concerned about how I had found out about the meeting and why I attended since it was to be a strictly IHS meeting. I was also advised that the Service Unit Director was cautioned by the Area Director to be restrictive as to what meetings I attended and what information was given to the Health Director.

I was disturbed by several things that concerning this IHS Draft Policy Bulletin.

1. At the meeting of November 19, 1981, the Area Representative CHS Coordinator advised a physician from Northern Cheyenne Service Unit that one of the reasons for the policy statement was that the physicians at Lame Deer were sending patients to contract facilities in Billings that probably should have been sent to Crow Indian Health Service facility. I was disturbed about this statement due to the fact that the gentleman is not a physician, does not see the patients here at Lame Deer but was able to make a general statement regarding patient care. The Northern Cheyenne Service Unit Physician advised him that patients were sent to Billings contract facilities based on the pathology of the illness or injury.

2. The second thing that disturbed me the following day was information given to me by the Northern Cheyenne Service Unit Director cautioning him to restrict information given to the Tribal Health Director and restrict the types of meetings the Tribal Health Director will attend. With all the budget reductions it is a recommendation of the Northern Cheyenne Tribe that Indian Health Service maintain an open door policy and allow tribes to be involved in what types of cuts are made as opposed to shutting them out.

   Keeping tribes informed as to what types of reductions are happening is very important. To this date the Northern Cheyenne Tribe, is not sure what happened to $20,000.00 dollars in CHS Funds. This money was to be used to pay for the cost of people who had been on the dererred surgery list allowing them to have some preventative surgery done. I was also advised that Area Office requested the $20,000.00 back and did take it back, eliminating surgery for several Northern Cheyenne patients, who will now have to wait until their illness becomes acute or a emergency situation. A letter was sent out on September 16, 1981, to the Service Unit Director, requesting information on this matter. He responded in a letter dated Spetember 28, 1981, which basically stated that Indian Health Service decided where the money should go. It is our opinion, the Northern Cheyenne Tribe, that $20,000.00 dollars was money to fund Health Services for the Northern Cheyenne people and the $20,000.00 should have been left in the budget to continue doing so.

3. Other Service Unit Programs affected by Budget Reductions

A. Pharmacy

Over the counter drugs have been eliminated and top flight medication has been reduced denying essential medications to chronically ill people who need it.

B. Personnel

Several positions have been lapsed

1. Medicaid Records Clerk
2. Information receptionist
3. Temporary Nursing Position
4. Dental Assistants
5. Motor Vehicle Operator
6. Two (2) Mental Health Specialist
7. Construction Inspector

C. Supplies

Budget reductions also effects the supplies. Obviously there is less x-ray being requested by physicians due to lack of x-ray supplies, less medicines provided by pharmacy and less supplies for public health nursing for the chronically ill patients. Both combination of the lack of supplies and GSA vehicles has resulted in a elimination of a satelite dental clinic at Labre School which services approximately 500 students, kingergarten through twelveth grade. It is the recommendation of the Northern Cheyenne Tribe, the Indian Health Service budgets be reduced as little as possible, especially in the direct services programs to avoid elimination of proper care for patients of the Northern Cheyenne Reservation.

4. Reduction in Tribal Programs

With the advent of Public Law 93-638 it was the assumption by tribes that this law would provide the authority for more tribal leaders to have more of a say to what their destinies would be. With the budget reductions, there arises many questions as to whether or not this dream will be fulfilled. There has been questions on several actions taken by the Indian Health Service Billings Area Office. Specifically in the area of Contracts with Tribal Health Departments and the methods used by Indian Health Service in reducing programs. As an example: the Northern Cheyenne Board of Health has had under contract for several years how a Medical Social Services Worker Contract. Contract Number HSA-244-82-0012. The letter was hand carried to the Northern Cheyenne Board of Health Chairman.

The letter stated such termination will be effective immediately upon receipt of this notice, which gave the Northern Cheyenne Board of Health approximately 2 hours notification. The Tribal Health Director then the following day, November 6, 1981, went to the Billings Area Office to find out the reason for termination. Questions came up as to why it was terminated. There was a rumor that the contract was an illegal contract due to that it was a contract for personal services circumventing the hiring freeze that was implemented by IHS. The Contracting Officer explained the clause of termination for the convenience of the Government and advised the Health Director that the Government did not have to tell why it was terminated. The Health Director then contacted the assistant Area Director in charge of administrative support programs who advised the Health Director that the contract was terminated due to the lack of funds. The Health Director asked for an extension of the contract and it was given for two weeks up to November 20, 1981, and at that time the contract was terminated. On December 7, 1981, at a Tribal Health Directors meeting in Billings Area Office, a memo was handed to all the Tribal Health Directors that were in attendance by the Area Director dated December 2, 1981. In this memo headquarters directed the Area office that "all fiscal year 1982 non 638 contracts except urban and CHR for continue of program operations shall be reduced to a level of not to exceed 90 percent of fiscal year 1981 funding level for their periods of performance and also consultation with the contractor, if the contractor is unwilling to negotiate the necessary reductions however a partial termination for the convenience must be done by the Government based on the Availability of Funds Clause and the Governments assessment of program priorities". The Assistant Area Director in charge of Administrative Programs was asked by the Tribal Health Director what this paragraph meant. The Tribal Health Director advised him that the interpretation of Tribal Health Directors was that there was funding available for the contract and the question was asked "Why the contract was terminate"? The Assistant Area Director advised the Tribal Health Director that the contract was cut for 2 reasons. 1) Lack of the availability of Funds.2) Being that it was an illegal contract. At the meeting on November 6, 1981, the contracting officer was asked if the contract was illegal, he stated that he was the one that made the decision as to whether the contract was illegal or not and he had reviewed the contract and made the decision that it was legal.

The Northern Cheyenne Tribal Health Director had several unanswered questions:

1. Why memo's were sent to Area Offices instructing cuts at certain levels and yet larger cuts were made in Tribal Programs?
2. Why funds were reduced without regard to the policy statement by Headquarters requesting Area Office Personnel to consult before taking action?
3. Since the contract was included IHS FY 81 Base, Why was it cut 100% due to lack of funds when the memo of Dec. 2, mandated reductions at a 10% level

B. Recently the Northern Cheyenne Board Of Health became aware that funding for Health Boards comes out the Hospital & Clinics Budget line item. This places administrative program in competition with Direct Health Care Dollars. It is the Northern Cheyenne Tribe's recommendations that funding for National, Area, and Local Health Boards come from the Budget Line Item Program Management.

C. Another concern of the Northern Cheyenne Board of Health is the Northern Cheyenne

Ambulance Service. Since 1977, The Northern Cheyenne Ambulance Service has been funded by grants and contracts through IHS. As of Jan. 31, 1980, the Tribal Health Department was notified that there would be no additional funding for Ambulance Services. A contract proposal was submitted to IHS Billings Area Offices under the authority of public law 93638 and the Tribal Health Department was notified by a letter that there was a slim chance of funding. A proposal was resubmitted again on June 17, 1988 to begin funding on Oct. 1, 1982. A request was submitted that since the first proposal submitted was not reviewed to see whether or not it fell under the criteria of PL-638, this request was that the proposal be reviewed as a 638 proposal. Again this proposal did not go through review process which most 638 proposals go through, no justification was given as to why. However, a counter proposal was submitted by IHS Billings Area Office recommending that the Northern Cheyenne Tribal Health Department use available resources to fund the program. Also, there was a break down of what funds IHS provides to the Ambulance Service, four (4) CHR Positions at 54,000, supplies at 3,000, Transfer Drivers approximately 23,000 and cost of the Transfer Vehicles at 4,000 and costs for Ambulance Vehicles at 27,000. The recommendation by the IHS Billings Area Office is that this would be a base for continuing the contract if additional resources such as CHR's and CETA would be looked at for manpower. The Northern Cheyenne Board of Health went on record June 30, 1981, at a special Board of Health meeting rejecting the options proposed in the counter proposal. Reason for rejecting the options proposed in the counter proposal is that the Northern Cheyenne Board of Health interpreted the 110,000 base that IHS had stated they were funding the program as inaccurate. The Northern Cheyenne Board of Health felt that the CHR's in the Ambulance Service were not specifically put in by IHS. The CHR positions came to the Northern Cheyenne Board of Health and the Board were the ones that made the decisions. The IHS Clinic break out the figure of supplies at 3,000, the figures of 27,000 dollars for the GSA Ambulance Vehicles were accepted at face value but after reviewing the costs of the vehicles, the Northern Cheyenne Board of Heatlh came up with a figure of approximately 12,000. The cost for Transfer Drivers and the GSA Vehicles that they use were not part of the Ambulance Service System and therefore could not be included in that budget. So approximate figure of 15,000 for supplies and GSA Vehicles is what the IHS have in funding. The Northern Cheyenne Board of Health also rejected the counter proposal on the bases that using additional CHR's in the program would take away from the CHR's functions and effectively hurt the program by not allowing the CHR Program to fill their objectives and goals.

Presently, the Northern Cheyenne Ambulance Service is being funded by the Northern Cheyenne Tribe. In order to continue the Ambulance Service Program, one of the objectives of the program was to start billing to see what costs could be recovered. The Northern Cheyenne Ambulance Service began billing medicaid for those patients that were eligible. A bill of approximately 34,000 dollars was sent to the Service Unit for Ambulance Calls that were made from Feb. 1981 to Sept. 1981. On Dec. 8, 1981, a letter was received from the Service Unit Director informing the Northern Cheyenne Board of Health that their position on further support of the Ambulance Service System on the Northern Cheyenne Reservation remains unchanged and that they are already supporting the system at the rate of approximately 110,000 per year and cannot commit any additional funds for Ambulances Services. They also stated "With the decrease in our appropriattions we cannot forsee any possibility that we will ever be able to provide additional resources to the Ambulance System." It is the opinion of the Northern Cheyenne Board of Health that priorities of the tribe and IHS is the direct medical care provided to patients. The Ambulance Service is one component of the system that provides direct care at the scene of an accident, illness, or injury and in transportation. However, the Northern Cheyenne Tribe has been unable to get this program funded through contracts with IHS when they do provide contract funds to other tribes. It is also the opinion of the Northern Cheyenne Tribe that public law 93638 intent was to allow Tribes develop capabilities to run programs and become sufficient. This program is funded by the Tribe and part of the self sufficiency of the Program is recovering costs through a billing system. At this time we are unable to receive any information as to why IHS will not pay Ambulance Service costs. The Northern Cheyenne Tribe places a strong emphasis on the Ambulance Service Program to provide quality care and transportation for the Northern Cheyenne People. Much more support is needed from IHS to continue such a program. The Northern Cheyenne Board of Health would like to make two (2) recommendations at this time. 1.) In order to keep direct services from budget reductions , it is our recommendation that the budget cuts be IHS Program wide and not by line item. We would also recommend that Tribes be actively involved in the actual decision of what reductions will be made by IHS. 2.) Is that Tribal Health Department, Area Health Boards be funded out of the budget line item Program Management as opposed to hospitals and clinics, thus eliminating competition for funds in hospitals and Clinic's budget that will directly provide for patient care services.

Thank you.

Respectfully submitted,

David Means, Director
Northern Cheyenne Tribal Health Department

Senate Select Committee
on Indian Affairs
Over Sight Hearings

Billings, Montana
December 21, 1981

CHR SUPPORT DOCUMENTS

Direct Health Care

Screening and Direct Care - Tribal CHR programs are in various stages of development. This is indicated in the variation of scopes of work reflected in the 234 CHR contracts IHS has with 25 states throughout the United States. The types of services provided by CHR personnel vary according to the size of the program and the skill levels of CHR personnel. However, an overview of the service categories and a brief description is provided in the following summary:

PATIENT CARE SERVICES BEING PROVIDED UNDER CHR CONTRACTS AS REPORTED BY TRIBES AND IHS AREAS, JANUARY 1979

Patient Care Category	Specific Description (Examples)	Estimated Person Years Reported
Alcholism/Drug Abuse	Counseling with alcoholics/drug addicts, follow-up, etc.	49.50
Communicable Disease	Dispense prescribed medications, determine signs, assist in immunization clinics, follow-up collect sputums, give and read PPD's, etc.	70.51
Dental	Monitor fluoride in water, assist with flouride mouth rinse, assist dentist at chariside, provide oral hygiene counseling, takes impressions etc.	40.71
Direct Disease	Use protocol to identify symptoms, select a stage, treat and or assure treatment and follow-up. Take vital signs. Take throat cultures, change dressings, clean wounds, first aid, give insulin shots (LPN's and RN's only) give physical therapy, inspect feet, counsel on exercise, monitor medications, etc. Upper Respiratory Infection Streptococcal Disease Control Diabetes Diarrhea Control Hypertension	139.83
Ear	Conduct screening clinics, operate Beltone Machine, operate audiometer, (after special training) assist in ENT clinics, assist with earmolds adjust hearing aids, otitis media follow-up, etc.	17.62

Patient Care Category	Specific Description (Examples	Estimated Person Years Reported
Emergency Medical	Services as first responder, administers advanced first aid to accident victims, emergency delivery of babies, treat dog and snake bites, administer cardio pulmonary resuscitation, serve as Emergency Medical Technicians, council suicide attempts, ambulance attendants, assist National Guard with stranded families and assist in evacuation, etc.	153.02
Environmental Health	Conduct rabies clinics, give rabies shots to dogs, inspect homes for hazards, takes water samples and performs tests, extracts blood samples from animals in plague control surveys beaver dams by horseback, inspect food service areas, feasts, follows-up on dog bite cases, etc.,	104.55
Eye	Assist in vision screening clinics, test school childrens vision with eye chart, deliver, adjust and repair eye glasses, serves as optometric assistant to the Area Optometrist when he visits the reservation with the Optometric Mobile Unit, do post-surgical follow-up as directed by physician, assist with Trachoma survey, etc.	31.45
Maternal and Child Health	In clinics, measures head circumferences, take histories, in home pregnancy testing, take vital signs on high risk children, take hematocrits, in the hospital assist in labor and delivery, counsels on breastfeeding, obesity and fetal alcohol syndrome, etc.	60.92
Mental Health	Intervention and referral of abused and neglected children and battered spouses, direct family planning, crisis intervention, home training for the developmentally disables, recreation specialist, marital counseling, child rearing practices, etc.	34.13

Patient Care Category	Specific Description (Examples	Estimated Person Years Reported
Nutrition	Conduct WIC clinics, take 24 hour food recalls, counsel in nutrition, follow-up on blood pressure, conduct special formula program, etc.	1.25
Other Clinics	Take vital signs, EMT's assist in emergency room, participates in hypertension clinics, takes hematocrits, collect specimens, perform tine tests, assist physician, assist with school health programs, Clinic Coordination, serve as patient advocates, interprets, etc.	144.37
Senior Citizens	Assistance in meal preparation, administers exercise and recreation programs, sprays homes for insects, cleans, assists stroke victims and handicapped with physical therapy, explains medications, monitors appointments, cooking meals, etc.	76.30
Specific Home Health Care	Takes vital signs, patient follow-up, counseling, supervision of medication, physical therapy, change dressings, visit all newborns, etc.	62.13

The following represent examples of specific direct care service:

1. Emergency Medical Services:

Emergency medical service activities represent one of the best examples of how CHR's have utilized their existing skills and expanded their capabilities to best respond to community medical needs.

Ten years ago it was difficult to find ambulance services in Indian country. Today, owing largely to the management and manpower services afforded by the CHR program, such life-saving service is available to most communities. Specifically, in FY 1979 approximately 153 man years of CHR time was identified in the provision of emergency medical response and transport services. Community based CHR's, in addition to staffing ambulance services are being trained as emergency medical first responders, and equipped with mobile radios and medical kits. These first responders are being dispatched to the scene of medical emergencies within a 15-minute response time to provide life-support until the ambulance arrives. Given the high incidence of morbidity and mortality associated with trauma, this is a dramatic improvement over the response time of 1-3 hours which have been a common experience in the recent past.

2. Disease Intervention

Tribes have begun to include more specific disease intervention activities within the scope of their CHR program contracts. A number of CHR programs are currently developing protocols for primary care in minor acute disease specific categories and the management of selected chronic disease. Those CHRs who provide direct health care services have become a crucial element of the health care delivery team on many remote reservations. Activities in the evolution of the CHR program have included the development of Tribal programs in which CHR's have been used to identify symptoms and stages of various diseases, such as infant gastroenteritis and upper respiratory infections according to established criteria to channel the patients for appropriate treatment.

(Two specific examples: (1) Papago project
(2) Strep project (Navajo)

B. Utilization of Health Services

The CHR program has impacted on virtually every IHS community health program initiative by contributing directly or indirectly by facilitating patient utilization of existing health care services. Examples of CHR impact on selected major health initiatives are reflected in the following activities involving CHR personnel:

1. Immunization - tracking and follow-up on children in need of immunizations; contacting parents, setting up clinics and clinic appointments, transport of children as needed, update of immunization records.

2. Diabetes - assist in regular IHS clinics, conduct screening clinics, monitor medications and appointments, conduct special nutrition classes.

3. Hypertension - conduct screening clinics, council on nutrition/smoking/alcohol use, monitor medications and blood pressures, conduct weight control classes, patient monitor and follow-up through home visits.

4. Maternal and Child Health - assist in IHS/MCH clinics, monitor appointments, assist in family planning clinics, identify high risk target groups, home visit follow-up and family planning counseling.

Note: All direct health care services proivided by trained CHR personnel is provided under the supervision of the appropriate medical personnel.

A cost benefit aspect fostered by the CHR programs in that the provision of services in preventive health, early response to an emergency condition and early intervention in disease identification has direct bearing on the potential serverity of morbidity, and consequently the total cost of treatment.

TRIBAL HEALTH PROGRAM DEVELOPMENT

In 1968 the CHR Tribal Health Contracts with IHS represented the first major step taken by tribes to administer and manage health programs. The experience gained by administering CHR programs provided tribes the opportunity to develop and strengthen their management capabilities. Tribal organizations began to build management systems which allowed an expansion of their program base.

The growth of tribal health program management is reflected in the number of health facilities managed and operated by tribes. Based on 1980 statistics tribes operated four hospitals and 252 Clinics and 2 Extended Care Facilities. In addition the cost of tribal health contracts funded by the IHS has increased from $17.4 million in fiscal year 1975 to $74.0 million in fiscal year 1979.

In January 1979 the IHS surveyed all tribes that administer CHR contracts for the purpose of reviewing CHR program acitivities and current trends. In each area tribal organizations stated that in fact the CHR program was the catalyst for individuals to move into health careers; and for tribes to form Health Departments. The following are excerpts from the 1979 CHR Survey:

I. Development of Health Committees, Health Boards and Health Department

Part I of the 1979 survey was aimed at examining the affect of the CHR program on the development and involvement of tribes and members of the Indian community in the provision of health care; and as important the attitudes and awareness of all aspects of health. Indian people no longer look to the IHS as the sole provider of their health care. Instead, the Indian people now recognize that the Tribe too has a significant role in health care delivery. The continual growth of the CHR program and the implementation of P.L. 93-638 has provided additional impetus for the development of this attitude.

Selected comments by Tribal Organizations and IHS officials illustrate how the CHR program has precipitated tribal health program development, expanded, available resource, and provided support for tribal programing.

"Since the beginning of the CHR Program, eighteen (18) tribal health departments are established and are in operation." (Aberdeen Area IHS)

"As for the C.H.R. serving as a nucleus for Tribal Health Services the program has been a catalyst for services such as: A. Immunization B. Environmental Health C. Ambulance Service Training D. Clinic opening --- E. Other health clinics ---F. Dental (services) G. Mental Health H. Alcoholism." (Red Cliff Band of Lake Superior Chippewas) Bemidji Program Office.

"The Health Planning Office has relied specifically on the CHR data and knowledge concerning the health status of the St. Croix Tribal people. Without this data and knowledge integrate (sic) parts of the Tribal Specific Health Plan (P.L. 94-437) could not of been developed. (St. Croix Tribe of Wisconsin) Bemidji Program Office.

"The development of the health departments within the tribe, initiat by the success of their Community Health Representative Program, has to a closer coordination of these programs and better utilization of staff and services." (San Carlos Apache Tribe) (Arizona) See PHX-B-3.

"Be it further resolved, that the Trenton Indian Service Area Corporation Board of Directors recognizes that the CHR Program has i fact been the catalyst for: 1. the Tribe to form a Health Departmen 2. individuals to move into health careers 3. more efficient utilization of existing services 4. extending health care to the community 5. developing other community programs where there was a need." Resolution #1-46-79, January 9, 1979. (Trenton Indian Servic Area Corporation) (North Dakota) Aberdeen Area.

II. Expanding Tribal Resources and Providing the basis for brining other Resources to Tribal Health Programs

This section provides further evidence of the leadership role assert by various CHR programs. The CHR also play a significant role in identifying resources other than those of the IHS which the Indian person is eligible. This is especially apparent in the identificati those individual who are eligible for medicare and medicaid. The CH work closely with both the individual and the IHS staff to assist in obtaining the appropriate authorizations.

CHR's are able to provide intensive follow-up and home health care th would otherwise be unavailable in the Indian community and reservati The availability of a trained CHR to provide such follow-up and care significant impact on the entire Indian community particularly the e population.

"The Health Program has a W.I.C. Program serving 105 women, infants, children. It was possible to get this program because of C.H.R.'s w available to administer the program." (Keweenaw Bay)

The CHR's have assisted the Senior Citizens ------ and obtaining a Senior Citizen's Center for them." (Keweenaw Bay)

"C.H.R.'s have done all preliminary work on setting up a Tribal garb pick-up and disposal system. This service has reduced the risk of illness and rodents here." (Keweenaw Bay)

"In Previous years, people went to a doctor only in an extreme emergency. The importance of regular checkups was unknown. Since t C.H.R.'s have been serving the community, the picture has changed to where people are not afraid of doctors, dentists and white man's medicine." (Keweenaw Bay)

"C.H.R.'s were in the planning process to establish an Alcoholism Treatment Center and Halfway House at the Tribal Center. "The Halfwa House has been in operation for 4 years. The C.H.R.'s saw the need were willing to take the initiative to bring the problem into the op and do something about it." Bemidji Program Office.

"The trust placed on these individuals by local comunity people more than justifys their existence. Many proposed Tribal Health Programs became a reality because of the legwork and the persistant nature of most CHR's. (Inter-Tribal Council of Michigan, Inc.)

"--the CHR Program works with many other health programs and resourc including Public Health Services." (Papago) (Arizona)

"Our CHRs do provide some home nursing care to persons who otherwise would have to be in longterm chronic care units for nursing homes." (Alaska Area)

On Northwest reservations, CHR involement has seen the development o well child clinics staffed by county community health nurses; specia community programs for the health maintenance of tribal elderly (Kit County, Washington has a senior service van which provides foot care health screening and health education); and women's health care (Kit County also has a special mobile women's health vehicle which does pregnancy counseling, PAP smear testing, family planning, breast examinations and general health education with an all-woman staff).

III. Providing opportunities for Career Development

"Several of the expereinced CHR's have had upward mobility in job status. They have taken jobs as CHR Coordinators, Tribal Health Planners, and in the future those Tribal Health Planners will be Tri health Program Administrators." (Inter-Tribal Council of Michigan, I Bemidji Program Office.

Former employees of the CHR Program are now "Tri-County Water Association Director; EDA Coordinator; BIA Social Service Case Work IHS Mental Health; Assistant Director, Teton Ambulance Service; BIA employee, Promise Day School. (Cheyenne River Sioux Tribe) Aberdeen

"The IHS - CHR program has been funded over the past 2 years, [illegible] several instances outreach aides funded under CRIHB have become [illegible] directors or enrolled for professional training." (California).

The documentation of CHR program effectiveness during the past decade is evident in:

	FY '80	FY '69	% change an increase
Outpatient Visits:	234,584	146,156	+ 51%
Direct Patient Admissions:			
Admissions (adult/pediatric)	3,847	2,927	+31%
Hospital Days (adult/pediatric)	13,849	18,504	-25.2% (reduction in hospital days)
CHS (Contract Health Service):			
Referral to specialty hospitals/Doctors			
Admissions	5,671	4,612	+23%
Hospital Days	26,231	31,803	-17.5% decrease
Total Admissions: (Direct and Contract)	9,518	7,539	+26%
Total Hospital Days: (Direct and Contract)	40,080	50,307	-20.3%

(Statistics from Indian Health Service, Billings Area, serving 40,000 Indians in the States of Montana and Wyoming.)

Optometry Clinic
PHS Indian Health Facility
Lame Deer, Mt. 59043

January 23, 1980

Sir:

I began holding Optometry clinic at the Billings Indian Center about one year ago. Visits began at the request of Mr. Kenny Nicholson. They are justified by the difficulty Billings residents have using the clinics at Crow Agency and Lame Deer. Most of the patients seen, approx. 1/3 - 2/3 in each visit, are Crows or Cheyennes.

Initially CHRs from Crow and Lame Deer were invited to participate in the program on alternate visits. Some months ago, partially from my own observations and partially at the request of Center personnel, I began to invite only the Lame Deer CHRs. The key factor in this decision was reliability. Your CHRs can be counted to be at the Center ready to work when they are needed.

I hope you will continue to allow your CHRs to participate in this program. Without your people visits to the Center would have to be discontinued.

I cannot tell you how long I will have to rely solely on your CHRs. Should conditions change the practice of Crow and Lame Deer CHRs providing support on alternate visits would again be used.

Henry J. Wirth OD
HSO. USPHS
C. Optometry Clinic

cc. Service Unit Director
CHR Director

HJW/hjw

CHS SUPPORT

DOCUMENTS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
Health Services Administration

Some instances in which failure to intervene leads to ultimately increased costs (financial and human)

Strabismus - when initially diagnosed, it could not be classified as emergent - that is, correction could still be achieved if surgery postponed. But if this "emergent" designation precludes doing surgery at all, the child will progressively + irretrievably lose the sight in one eye.

Valvular heart disease: such as mitral stenosis. Some stabilization through medication may permit delaying surgical repair; but if repair is not done early ("pt is stable, no congestive failure, we can still wait") and heart failure occurs, doing surgery then would at best arrest deterioration, but could not regain lost ground, leaving the person a cardiac cripple - expensive to maintain status quo, at risk for complications requiring expensive in-patient treatment, and living on disability payments for rest of life.

Traumatic cataract - nonemergent initially, but if not treated within a certain time, goes blind, one or both eyes.

possible angina pectoris. If so-called stable angina, is not immediately emergent; but if diagnostic studies are therefore deferred, you may pay instead for CCU treatment after heart attack, plus rehab, plus disability payments, etc. Same with postponing bypass surgery if it's known to be needed but on less-than-emergent basis.

head trauma patients. We often take a calculated risk (or rather, the patient does without realizing what we're not doing) if we don't get a CT scan to rule out bleeding inside the skull. If we postpone until definite symptoms appear, the patient could die or be crippled - if crippled, there's a fair chance Uncle Sam will pay part of the bill for support.

These are only a few such entities. One might include certain screening programs, and certain medications. In a poverty-stricken area, postponing a service might frequently mean it's unavailable - period. By the time illness evolves into a (preventable + foreseeable) emergency and someone finally OK's payment, it costs much more & has more expensive sequelae.

98
99) combine

CONTRACT HEALTH SERVICES
BILLINGS AREA IHS POLICY BULLETINS:

BULLETIN #	DATE	SUBJECT
82.1	11/09/81	Delivery of Dental Care
82.2	11/10/81	Management of the Contract Health Service Program
82.3	11/10/81	Abortions Funded From Contract Health Service
82.4	11/13/81	Pharmacy Costs at the Flathead Service Unit
** 82.4	11/10/81	Delivery of Mental Health Care
82.5	11/12/81	Mental Health Serv ices Funded from Contract Health Services
82.6	11/12/81	Outpatient Services Charged to Contract Health Service Funds
82.7	11/12/81	Eyeglasses Purchased from Contract Health Service Funds
82.8	11/15/81	Patient and Patient Escort Travel
82.9	11/17/81	Referral Laboratory and Radiology Costs Charged to CHS funds
82.10	11/18/81	Sterilization Procedures Funded From CHS Funds
82.11	11/18/81	Notification to Indian People of the Billings Area Policies (Bulletins) on Contract Health Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Policy Bulletin (No. [illegible])
(7 pages)
November 9, 1981

Memorandum

Refer to: DE(G))

Dental

Date November 9, 1981

From Director, Billings Area
Indian Health Service

Subject Delivery of Dental Care

To All Service Unit Directors

Budgetary constraints for FY-1982 require the dental care delivery program be realigned to meet the available resources. Projected costs of services exceed available resources. Therefore, certain services must be removed from the program and calculations repeated until costs of the services to be provided equal the available resources. It is important that the selected services to be provided within the available resources follow a logical and equitable sequence and meet the basic principles of public health dentistry--especially prevention of oral disease and early intervention in the disease process.

In the effort of meeting the budgetary constraints, you are directed to realign the Service Unit contract dental care program to Level I and the direct care program to Level III. An explanation of each level of care, together with the selected dental services allowed within, follows:

LEVEL I
EMERGENCY DENTAL SERVICES

EMERGENCY DENTAL SERVICES: Emergency dental services are those necessary for the relief of acute conditions. Emergency dental care services include all necessary laboratory and preoperative work including examination, radiographs and appropriate anesthesia (local, general, sedative) for optimal management of the emergency. Emergency dental services shall include, but not be limited to, the following:

(a) Control of oral and maxillofacial bleeding in any condition when loss of blood will jeopardize the patients wellbeing. Treatment may consist of any professionally accepted procedure deemed necessary.

(b) Relief of life threatening respiratory difficulty and improvement of the airway (respiratory system) from any oral and maxillofacial condition. Treatment may consist of any professionally accepted procedure deemed necessary.

(c) Relief of severe pain accompanying any oral or maxillofacial conditions effecting the nervous system, limited to immediate palliative treatment but including extractions where professionally indicated.

(d) Immediate and palliative procedures for: 1) fractures, subluxations and avulsions of teeth, 2) fractures of jaw and other facial bones

DEPARTMENT OF HEALTH & HUMAN SERVICES

Billings Area IHS
Policy Bulletin No. 82-3
November 10, 1981

Memorandum

Refer to: CHS

Date November 10, 1981

From Director, Billings Area
Indian Health Service

Subject Abortions Funded From Contract Health Service

To All Service Unit Directors

No Contract Health Service funds will be used for abortions unless the IHS physician certifies in the record that abortion is required to prevent serious threat to morbidity or mortality. Each request for an abortion will have prior approval from the Service Unit CHS Committee. The Service Unit Director will assure that the intent to restrict payments for abortions is not violated by spurious justification.

J. R. Smith

DEPARTMENT OF HEALTH & HUMAN SERVICES

Billings Area IHS
Policy Bulletin No. 82,5
(3 pages)
~~November 12, 1981~~

Return assigned x
Copy to: FS LC
CHS
Physicians
AO
Dode

Memorandum

Refer to: CHS

Date November 12, 1981

From Director, Billings Area
Indian Health Service

Subject Mental Health Services Funded from Contract Health Services

To All Service Unit Directors

The enclosed "Contract Health Service Policy for Mental Health" provides guidance in establishing priorities for the expenditures of CHS funds for mental health services.

Priority 1 services are considered medical emergencies and may be authorized for payment. Priority 2 and 3 services may be authorized for payment after review of the case by the Area Mental Health Consultants.

Normal review to ensure that all regulatory requirements are met is mandatory.

J. R. Smith
J. R. Smith

Attachment

RECEIVED
NOV 18 1981
PHS Indian Health Center
Lame Deer, MT 59043

DEPARTMENT OF HEALTH & HUMAN SERVICES

Billings Area IHS
Policy Bulletin No. 82-7
November 12, 1981

Return original to me
Copy to: Optometry
CHS
JR Done

Memorandum

Refer to: CHS

Date November 12, 1981

From Director, Billings Area
Indian Health Service

Subject Eyeglasses Purchased from Contract Health Service Funds

To All Service Unit Directors

Effective this date, no eyeglasses may be purchased from Contract Health Service funds.

Individuals eligible for Medicaid should be encouraged to obtain their refractions and eyeglasses from private practitioners. If they do choose to use the IHS optometrist, and order glasses through the IHS contract, they will pay for their glasses.

We will pay for refractions for college students (not their dependents) to the extent that they could not reasonably expect to return to the service unit for the service; i.e., go to school at a distant point and do not return for the summer. The student will be expected to pay for his eyeglasses.

The contract for eyeglasses will remain in effect and Indian people may use this source of low cost eyeglasses. The rules on prepayment and control of cash collections will be adhered to.

J R S

J. R. Smith

Billings Area IHS
Policy Bulletin No. 82.8
November 16, 1981

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Copy to AO
CHS
Family Services

Date November 16, 1981

Refer to: CHS

From Director, Billings Area
Indian Health Service

Subject Patient and Patient Escort Travel

To All Service Unit Directors

Contract Health Services may be used for patient and patient escort travel with the following limitations.

> Patient travel - IHS personnel and vehicles or tribal contract personnel with responsibilities under their contract to provide transportation for patients should be the primary source of transportation of patients within the confines of the State. Transportation of patients is not a right and should not be authorized at the expense of CHS funds if the individual is able to provide his/her own transportation. CHS funds may be used for patient travel when there is no other alternative. The most economical source of common carrier that provides a reasonable schedule will be utilized.
>
> Patient escort - CHS funds may be used to furnish one escort to a child (eighteen and under) or to an adult who has a handicapping condition that precludes his traveling unassisted. Costs will be limited to the most economical common carrier plus a reasonable amount of funds for food and lodging. We suggest arrangements be made, whenever possible, to utilize low cost lodging and meals that are sometimes available around hospitals and are known to the social service department of the hospital.

The intent of this policy is to limit payment of patient and patient escort costs to the lowest level commensurate with the requirement that an individual not be denied an emergency service because he/she cannot afford the travel costs or cannot travel alone.

The payment of ambulance costs related to treatment of an emergency condition is a permissible charge to CHS.

J. R. Smith

[illegible] & HUMAN SERVICES

Billings Area IHS
Policy Bulletin No. 82.9
November 17, 1981

Memorandum

Refer to: CHS

① ~~File~~
~~CHS~~
~~LAB~~
~~Clin~~
~~AO~~
~~X-Ray Director~~
~~Sic~~

Date: Nov. 17, 1981

From: Director, Billings Area
Indian Health Service

Subject: Referral Laboratory and Radiology Costs Charged to CHS funds

To: All Service Unit Directors

The cost of referral laboratory will be charged to Contract Health Services in FY-1982. It should be recognized that the CHS budget cannot continue to support the level of referral laboratory procedures experienced in FY-1981. In FY-1982, the policy will be to refer out only those procedures that cannot be done at the IHS facility because the Technologists do not have the skills to do the test or where the test is done so seldom that it is uneconomic to maintain a supply of the reagent to do the test. Laboratory procedures will not be referred because of reduced staff or malfunctioning equipment. In order to support this action, all laboratory equipment should be covered by preventive maintenance contracts arranged by the service units.

Based on the FY-81 experience, the service units should be able to maintain the above level of lab referred services at the following annual cost:

Blackfeet	40,000
Crow	32,000
Fort Belknap	20,000
Fort Peck	24,000
Northern Cheyenne	14,000
Wind River	24,000
Rocky Boy's	9,000

The current cost of radiology services by contract radiologist cannot be reduced if we are to maintain or obtain accreditation of the IHS facilities. We will not agree to any contract ammendments that would increase the cost of contract radiology services.

The current cost of radiology and laboratory technologists at the Intermountain School will continue at the previously agreed rate for FY-1982.

J. R. Smith

DEPARTMENT OF [illegible]ALTH & [illegible] SERVICES

Billings Area IHS
Policy Bulletin No. 32,10
November 18, 1981

Memorandum

Refer to: CHS

November 18, 1981

Director, Billings Area
Indian Health Service

Sterilization Procedures Funded From Contract Health Service Funds

To All Service Unit Directors

No CHS funds may be used for sterilization procedures unless the IHS physician certifies in the record that the sterilization procedure is required to prevent serious threat to morbidity or mortality. Each request for a sterilization procedure will have prior approval from the Service Unit CHS Committee. The Service Unit Director will assure that the intent to restrict payment for sterilizations is not violated by spurious justification.

J. R. Smith

J. R. Smith

Received: 11/19/81 @ 9:55

DEPARTMENT OF H[illegible] SERVICES

Memorandum

November 17, 1981

Refer to: ASP

Director, Billings A.
Indian Health Service

Billings Area IHS Policy Bulletin - DRAFT

Service Unit Director, PHS I. Hospital, Crow Agency, Montana
Service Unit Director, PHS ; Health Center, Lame Deer, Montana

Please review the attached *draft* Billings Area IHS Policy Bulletin and forward your comments via telefacsimile immediately or no later than COB Thursday, November 19, 1981.

R. J. Raymond
for J.R. Smith

Attachment: 2 pages

SENT VIA TELEFACSIMILE TO:
Northern Cheyenne Service Unit DATE: 11-17-81 TIME:
Crow Service Unit DATE: 11-17-81 TIME: 11:09 BY: RDW

Rec: 11:30 - 11/17/81 rah

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Refer to: CHS

Director, Billings Area
Indian Health Service

Increased Utilization of IHS Hospitals

All Service Unit Directors

The four service units that have IHS Hospitals available have over the years increased the number of referrals to contract hospitals while reducing the number of patients treated in the IHS Hospitals. During the current period of reduced Contract Health Service funding, we will need to increase the use of IHS Hospitals and decrease the number referred to contract facilities. The following figures show the change that has occurred between FY-1976 and FY-1981.

	DIRECT ADPL		CONTRACT ADPL		%CONTRACT		% INCREASE
	FY-76	FY-81	FY-76	FY-81	'76	'81	IN CHS ADPL
Blackfeet	20.4	16.6	6.6	8.7	24	35	+46%
Crow-Northern Cheyenne	17.0	12.5	7.5	12.8	31	51	+64%
Fort Belknap	6.3	7.2	3.8	4.1	38	36	-5%
TOTAL------------------	43.7	36.2	17.9	25.6	29	41	+41%

You will note that the total ADPL is essentially the same for both years, but the distribution between direct and contract changed from 29% contract in FY-76 to 41% contract in FY-81, an increase of 41%. The Service Unit Directors are required to assess the changes that have occurred during the last few years and the impact of reduced CHS funds with the goal of obtaining a balance between direct and contract hospitals of 70% IHS Hospitals and 30% contract hospitals. This will require relatively small changes at Browning and Harlem, but will require a relatively major change at Crow/Northern Cheyenne where the contract hospitalization was split 50/50 between direct and contract in FY-1981.

The CHS budget projections for Blackfeet, Crow, Fort Belknap, and Northern Cheyenne will be based on the assumption that 30% of the total inpatient census will be in contract hospitals and 70% at the IHS Hospitals.

In recognition of the fact that the Northern Cheyenne Service Unit does not have control over who is admitted to the Crow Hospital and who is referred to contract facilities, we will include in the Crow projected CHS budget funds for the contract hospitalization costs for Indians from Crow and Northern Cheyenne. Crow would be responsible for all inpatient contract costs for the Crow and Northern Cheyenne Contract Health Service Delivery Areas. The Service Unit Directors and the Clinical Directors from the two service units will be responsible for developing the guidelines for the operation of the program, particularly the communication between the two service units.

To assist the two service units in developing guidelines for operation of the program, we suggest the following for consideration:

1. The Crow CHS committee will include a representative from the Northern Cheyenne Service Unit.

2. The CHS staff from the Crow Service Unit will be responsible for determining the status of CHS eligibility for Northern Cheyenne patients, who are ferre to a contract hospital, with respect to compliance with CHS regulations, policies, and procedures. Upon request, Northern Cheyenne CHS staff will participate in researching cases to determine CHS eligibility and availability of alternate resources. These procedures and responsibilities also apply to the use of contract hospitals by Northern Cheyenne patients not referred by Crow; i.e., emergency admissions.

3. Crow may not deny CHS funds based on non-notification if the patient or anyone acting on behalf of the patient contacts the Northern Cheyenne Servic unit within the required time limits. In this regard, Northern Cheyenne must notify the Crow CHS staff of contract admissions made known to them.

4. Northern Cheyenne Service Unit may not commit Crow CHS funds.

The Rocky Boy's Service Unit will be expected to use the Harlem facility to the extent possible for hospitalization of people from the Rocky Boy's Servic- Unit except that obstetrical cases from Rocky Boy's will not be required to deliver at the Harlem facility.

J. R. Smith

Here is a list of Over-the-counter drugs that will be affected .

Artificial Tears(Lacril, Liquifilm Forte, etc.
Lacrilube
Normal Saline Nose Drops
Cetaphil
Calamine Lotion
Bacitracin Ointment
Glycerin/peroxide Otic (= Debrox)
Isopropyl Rubbing Alcohol
Hand Lotion
Analgesic Balm
Mylanta-II
Betadine Ointment
Anusol Plain Suppositories
Eucerin
Sebulex Shampoo
Vanseb-T Shampoo
Encare Oval
Contraceptive Foam (Delfen, Emko)
Contraceptive Jelly
Quinine Sulfate Capsules 5 Grain
Vitamin b-1 Tablets 50mg
Vitamin b-6 Tablets 50mg
Condoms
Baby Aspirin Tablets
Tylenol Drops
Tylenol Elixir
Castor Oil
Robitussin Cough Syrup
Robitussin DM Cough Syrup
Kaopectate
Pedialyte Liquid
Feosal Drops
Magnesium Citrate Solution
Afrin Pediatric Drops
Afrin Spraypack
Sudafed Syrup
Sudafed Tablets(30mg is OTC)
Metamucil
Throat Lozenges
Chloraseptic Spray
Pediatric Vitamins(Poly-Vi-Sol Drops)
Triple-X Shampoo
Zinc Oxide Ointment
A&D Ointmentnt
Vaseline
Hydrogen Peroxide Solution 3%
Fostex Soap
Tinactin Cream and Powder
Total Eclipse
Lanolin
Iodine
Tylenol Tablets

OTC use of HC Cr&Ung
Gaviscon
Bisacodyl Tabs and RS
Glycerin RS
White ASA Tablets
ASA Rectal Suppos
Enteric Coated ASA
Calcium Tablets
Colace Capsules
Iron Sulfate Tablets
Meclizine
Vitamin C Tablets
Insulin
Insulin Syringes
Alcohol Swabs

Perhaps not everything here listed is a candidate for elimination

NORTHERN CHEYENNE BOARD OF HEALTH
NORTHERN CHEYENNE RESERVATION
LAME DEER, MONTANA

RESOLUTION NO. (81)

A RESOLUTION OF THE NORTHERN CHEYENNE BOARD OF HEALTH OPPOSING THE TRANSFER OF ANY CONTRACT HEALTH SERVICE FUNDING FROM NORTHERN CHEYENNE SERVICE UNIT TO CROW SERVICE UNIT.

WHEREAS, the Northern Cheyenne Tribe and Board of Health is charged with the responsibility of Insuring Quality Health for the Northern Cheyenne Tribe; and

WHEREAS, Indian Health Service has proposed to transfer Contract Health Service funds from Northern Cheyenne Indian Health Service Unit to Crow Agency Indian Health Service Unit; and

WHEREAS, if said proposed policy is implemented the Northern Cheyenne People will have less access to Specialized Care adversely impacting the health and well being of the Northern Cheyennes

THEREFORE BE IT RESOLVED, that the Northern Cheyenne Board of Health opposes the transfer of Northern Cheyenne Contract Health Service funds from Northern Cheyenne Service Unit to Crow Service Unit.

PASSED, ADOPTED AND APPROVED by the Northern Cheyenne Board of Health by (6) votes for passed and adoption and no votes against passage and adiption this (20th) day of November, A.D. 1981.

Thomas Rockroads Jr
Tom Rockroads, Jr., Chairman
Northern Cheyenne Board of Health

ATTEST:

Henry Scalpcane
Henry Scalpcane, Secretary
Northern Cheyenne Board of Health

NOTED AND FORWARDED

Allen Rowland, President
Northern Cheyenne Tribe

NORTHERN CHEYENNE BOARD OF HEALTH

P.O. BOX 6
LAME DEER, MONTANA 59043
(406) 477-6284

September 16, 1981

Mr. H.L. Frazier, SUD
Indian Health Service
Northern Cheyenne Service Unit
Lame Deer, Montana 59043

Dear Mr. Frazier:

At a regular meeting of the Northern Cheyenne Board of Health a problem concerning CHS Funds with your service unit has arisen.

It is rumored that the Billings Area Office has taken funds from the Northern Cheyenne Service Unit CHS budget and applied them elsewhere in the area.

It is the Board's understanding that CHS funds that have been allocated to the Service Unit are to provide services to the Northern Cheyenne's.

If the rumor is true then the Board's questions the reason for Billings Area Office re-allocating these funds.

On September 10, 1981 at a regular meeting of the Northern Cheyenne Board of Health the Board passed a motion for me to check into this matter.

At this time I would like to request any information that maybe available from your office concerning this matter.

Your cooperation will be appreciated and if you have any questions feel free to call me at 477-6722.

Sincerely,

David A. Means, Director
Northern Cheyenne Board of Health

cc: files
BGH

"PURSUING QUALITY HEALTH FOR THE NORTHERN CHEYENNE PEOPLE."

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
Health Services Administration
Lame Deer, Montana 59043

September 28, 1981

RECEIVED
SEP 29 1981
NORTHERN CHEYE
TRIBAL HEALTH DE

Mr. David Means, Director
Northern Cheyenne Board of Health
P.O. Box 6
Lame Deer, MT. 59043

Dear Mr. Means:

The funds allocated to the Billings Area are not specifically identified for any reservation or group of Indian people. The Area attempts to distribute allocation as fairly as possible and as early as possible to allow each service unit to plan their program for the year.

It should be recognized that the incidence of illness is not a controllable factor and there are situations where the demand for health services at one service unit or other is greatly above normal while at other service units the demand might not be as great. In the interest of providing at least emergency services to all Indians in the Billings Area, there are times when the initial allocations to the service units' needs to be adjusted to reflect the differences in demand.

This process of re-adjustment of allocations has occurred each year to some extent. The Northern Cheyenne Reservation has benefited from this process on numerous occasions through the years but this is the first year that they have been required to share some of their allocations with other service units.

Sincerely yours,

Helbert L. Frazier, Director
Northern Cheyenne Community
Health Center

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

TO : Whom it Concerns

DATE: 12-15-81

FROM : Jon Harwell, MD
CLINICAL DIRECTOR, NCSU

SUBJECT: Effect of budget restrictions upon CME

Currently funds reserved for Continuing Medical Education may not be spent for CME. This has two major effects:

1) PHS physicians are often non-specialists, practicing general medicine at relatively remote sites, some with only medical school and one years internship. For any practitioner, medicine is expanding so rapidly that it's hard to keep current. Doctors can stay aware of some advances by scanning journals. But for most of us, additional basic knowledge is needed too - mainly because the scope of general practice is so broad it can take years to assume full competence in the many areas where expertise is required. Furthermore most docs must have 50 hours' CME annually to retain licensure. PHS physician salaries are not competitive with those in the private sector. If physicians cannot obtain adequate CME, in terms of subject matter and quantity, it is patient care which suffers; additionally, unnecessary referrals to specialists occur much more frequently; and the overall cost of patient care rises substantially.

2) Nearly all PHS physicians were induced to enlist by, among other things, guarantees of money and time which the government would provide for acquisition of CME. This was represented as an entitlement, same as housing, salary, medical care, etc. An opinion by the Region 8 Attorney suggests we have good cause to regard CME as an entitlement.

When the government unilaterally and arbitrarily deprives its physicians of a guarantee, reneges on a promise, the effect on morale is pronounced. The conclusions which many have drawn is "don't trust the government - its promises are worthless!" and "the bureaucracy has no concern for its medical professionals, expecting them to work long hours for low salaries without professional-educational support, and certainly has no real commitment to patient care, which we can't adequately provide without CME." This causes anger, resentment, cynicism, bitterness, and ultimately, causes those who have acquired some practical field experience to drop out & turn the business over to unsuspecting rookies who begin the process all over again.

This is not hypothetical - I've seen it occur repeatedly in the past 4 years.

Senate Select Committee
on Indian Affairs
Over Sight Hearings

Billings, Montana
December 21, 1981

Tribal Programs Support
Documents

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION

OCT 04 1981

Our Reference: AS/C
HSA-244-82-0012

BILLINGS AREA
INDIAN HEALTH SERVICE
2727 Central Avenue
P. O. Box 2143
Billings, Montana 59103

LETTER NOTICE OF TERMINATION

Mr. Thomas Rockroads Jr., Chairman
Northern Cheyenne Board of Health
Northern Cheyenne Reservation
Lame Deer, Montana 59043

Dear Mr. Rockroads:

Effective Date of Termination.

You are hereby notified that your Contract No. HSA-244-82-0012 (hereinafter referred to as "The Contract") is hereby terminated for the convenience of the Government, in accordance with the clause thereof entitled "Termination of Convenience of the Government." Such termination will be effective immediately upon receipt of this notice.

Cessation of Work and Notification to Immediate Subcontractors.

(A) You shall stop all work, make no further commitments and perform no further elements of the scope of work except (1) to the extent necessary to perform any portion thereof not terminated by this Notice, or (2) to the extent the Contracting Officer authorizes you to continue work in process for reasons of safety, or otherwise to prevent undue loss to the Government. (If you believe the authorization referred to in paragraph (A) (2) is necessary or advisable, you shall immediately notify the Contracting Officer by telephone or personal conference and obtain instructions.) To the extent of completing the work in process, including the final delivery of all items and reports for completed work, you are required to take all precautions to prevent undue loss to the Government. You shall keep adequate records of your compliance with this paragraph (A) showing, (i) the date you received your Notice of Termination, (ii) the effective date of such termination, and (iii) the extent of completion of performance on such effective date.

(B) You shall give Notice of Termination to each of your immediate subcontractors (including suppliers) who will be affected by the termination of your contract. In such notice you shall (1) give him the number of your contract with the Government; (2) state that it has been terminated for the convenience of the Government; (3) give him the name and address of the Contracting Officer; (4) instruct him to stop all work, to make no further shipment or committments, to place no more orders and to terminate all subcontractors under this contract with you (subject to the same exceptions stated in paragraph (A); (5) direct him to submit his settlement proposal promptly in order to expedite settlement; and (6) request him to give similar notices and instructions to his immediate subcontractors.

(C) You shall notify the Contracting Officer of the work completed under the contract and arrange with him for final delivery or other disposal of deliverables.

(D) You shall forthwith transfer title to the Government and deliver in accordance with any instructions of the Contracting Officer, all items of Government property (including subcontractors, Government property which under the terms of the subcontract or purchase order concerned, you have the right to take over) authorized for procurement under the contract.

(E) You shall notify the Contracting Officer of any pending legal proceedings which relate to any subcontracts or purchase orders under the terminated contract or which have resulted in or which are intended to result in a lien or encumbrance on any terminated inventory other than termination inventory you propose and are authorized to purchase, retain or dispense of. The Contracting Officer shall also be promptly notified if any proceedings brought after receipt of this Notice.

(F) You shall submit your settlement proposal and take such other action as may be required by the Contracting Officer or under the termination clause contained in your contract.

Termination Inventory.

In connection with settlement of your claim it will be necessary to establish that all your termination inventory and that of your subcontractor has been properly accounted for. For detailed information, see Subpart 1-8 of the Federal Procurement Regulations (41 CFR 1-8.5).

Completed Work.

Subject to paragraph 1-8.306 of the Federal Procurement Regulation (41 CFR 1-8.306), you will invoice acceptable completed end item under the contract in the usual way and not include them in your settlement proposal. The Government shall be liable only for payment in accordance with Payment Provision of this contract for service rendered prior to the effective date of termination and to complete the work in paragraph (A), above. No other termination settlement will apply.

Settlement with Subcontractors.

You remain liable to your subcontractors and suppliers for claims arising by reason of the termination of this subcontract or orders. You are requested to settle such termination claims as promptly as possible. For purposes of reimbursement by the Government, each settlement will be governed by the provisions of Part 1-8 of the Federal Procurement Regulations (41 CFR 1-8).

Mr. Thomas Rockroads Jr., Chairman
Northern Cheyenne Board of Health

Officer in Charge of Settlement.

The officer named below will be in charge of the settlement of your claim, any matters not covered by this Notice, may be directed to him.

Acknowledgement of Receipt of Notice.

Please acknowledge receipt of this notice as shown on below.

Sincerely yours,

Ronald J. Vallie
Area Grants and Contracting Officer

Billings Area Indian Health Service
P. O. Box 2143
Billings, Montana 59103
(406) 657-6123

ACKNOWLEDGEMENT OF NOTICE

The undersigned hereby acknowledges receipt of a signed copy of the foregoing Notice on November 5, 1981.

Northern Cheyenne Board of Health
NAME OF CONTRACTOR

BY: Thomas Rockroads Jr.
Thomas Rockroads Jr.
Chairman, Tribal Health Board
Northern Cheyenne Board of Health
Northern Cheyenne Reservation

cc: Assistant Area Director, Administrative Support Programs

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
Health Services Administration

NOV 9 1981

BILLINGS AREA
INDIAN HEALTH SERVICE
2727 Central
P. O. Box 2143
Billings, Montana 59103

Our Reference: AS/C
HSA-244-82-0012

Mr. Thomas Rockroads Jr., Chairman
Northern Cheyenne Board of Health
Northern Cheyenne Reservation
Lame Deer, Montana 59043

Dear Mr. Rockroads:

You are hereby notified that the effective date of termination as specificed in "Letter Notice of Termination," dated November 4, 1981, regerding Contract Number HSA-244-82-0012 is extended to November 20, 1981, rather than the date the notice was received. No other instructions/directions contained in the notice of termination have been changed.

This extension is granted at the verbal request of the Assistant Area Director, Administrative Support Programs.

If you have any question regarding this extension, please contact the Contracting Officer as specified in the notice of termination.

Sincerely yours,

Ronald C. Vallie
Area Grants & Contract Officer

cc: Assistant Area Director, ASP

ELECTRONIC MAIL

INDIAN HEALTH SERVICE

Headquarters

ELECTRONIC MAIL SYSTEM

Date: Dec. 2, 1981
Time:

From: Name: Gene Watson
Title: Supervisory Procurement Analyst
Office: Contracts and Grants Management, IHS

---------- INSTRUCTIONS ----------

Deliver To: Name: All Area/Program Directors & Contracting Officers
Title:
Office: All Areas

When: ASAP

Print Info: No. of pages =3 3
No. of copies to be made = 2 for each Area
Paper size = 8-1/2x11
Print pitch size = 12
Set left margin = 10
Note!

Special Notes: One copy for Director and one copy for Contracting Officer

RECIEVED ON WANG FROM HEADQUARTERS 12/02/81 12:04 p.m. by L.Christianson DOC # 4848A printed out at 12:05 p.m. 3 pages

Rec'd 12-02-81 12:30 PM eblatt
Original: AD
cc:
AS/C
ASP
[illegible]

Associate Director for Administration
Indian Health Service

Fiscal Year (FY) 1982 Funding Limitations

All Area/Program Directors
and Contracting Officers

Due to the unusual funding circumstances during the first quarter of FY 1982, and the probability of subsequent funding limits for the remainder of the fiscal year, the following actions are necessary for all contracts which incorporate the Availability of Funds clause:

1. All FY 1982 P.L. 93-638 contracts except individual Community Health Representative (CHR) contracts shall be reduced to a level not to exceed 90 percent of the FY 1981 funding level for their periods of performance.

2. All FY 1982 P.L. 93-638 individual CHR contracts shall be reduced to a level not to exceed 82.6 percent of the FY 1981 level for their periods of performance.

3. All FY 1982 non 638 contracts, except urban and CHR, for continuing program operations shall be reduced to a level not to exceed 90 percent of the FY 1981 funding level for their periods of performance.

4. No new urban contracts will be negotiated until further notice. Current urban contracts may be extended on a monthly basis at a level not to exceed 90 percent of the FY 1981 monthly funding level.

5. All FY 1982 non 638 individual CHR contracts shall be reduced to a level not to exceed 82.6 percent of the FY 1981 funding level for their periods of performance.

Non 638 contracts requiring modification in accordance with these instructions require consultation with the contractor. If the contractor is unwilling to negotiate the necessary reductions, however, a partial termination for convenience must be done by the Government based on the Availability of Funds clause and the Government's assessment of program priorities.

The Indian Health Service (IHS) allowed 100 percent of FY 1981 funding for the period October 1 through November 20, 1981 in accordance with our memorandum of October 13, 1981. Total FY 1982 funding for the above listed contracts, however, must be limited to the levels indicated. This means that any listed contract funded at a provisional level of 100 percent of the FY 1981 level or higher through November 20, 1981 will have to be modified to the presently anticipated availability of funds level as shown above.

The HSA, Office of Fiscal Services, Systems Review and Analysis Unit authorizes drawdowns under the letter of credit based on a copy of the signed contract and the contractor's approved spending plan. Therefore, whenever you issue a contract modification, a copy of the modification must be sent to Mr. DeManche along with any revised spending plan.

James Danielson

Doc. Id. 0823F

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
Health Services Administration

JUL 7 1981

RECEIVED
JUL 8 1981
NORTHERN CHEYENNE
TRIBAL [illegible]

BILLINGS AREA
INDIAN HEALTH SERVICE
2727 Central
P. O. Box 2143
Billings, Montana 59103

Our Reference: CHS

Mr. David A. Means, Director
Northern Cheyenne Board of Health
P.O. Box 6
Lame Deer, Montana 59043

Dear Mr. Means:

This is to acknowledge receipt of your letter of June 30, 1981, and the "Proposal - Contract for Ambulance Services", dated June 17, 1981.

We regret to inform you that the funding available to the Billings Area is insufficient to provide support to the June 17, 1981, proposal which has a cost of $133,200. The suggested options in our letter of March 16, 1981, represents the maximum resources that are available through the Indian Health Service to support the Northern Cheyenne Ambulance Service.

The current funding situation in the Indian Health Service does not permit the increase of resources to any program, no matter how worthwhile. More and more, it will be necessary to look to reallocation of current resources to meet high priority needs at the expense of lower priority needs. The March 16, 1981, letter suggested several options to the Health Board that would, in effect, reallocate resources from other on-going programs to the ambulance service. We interpret your June 30, 1981, letter as a Health Board decision that the current activities of other available personnel have an equal or higher priority than the ambulance service. We accept this decision as being within the prerogative of the Health Board.

We are still willing to discuss with the Board any other options that might be proposed that are within the resources available as outlined in our March 16, 1981, letter.

Sincerely yours,

J. R. Smith, Director
Billings Area
Indian Health Service

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
Health Services Administration

MAR 16 1981

BILLINGS AREA
INDIAN HEALTH SERVICE
2727 Central
P. O. Box 2143
Billings, Montana 59103

Our Reference: CHS

Mr. Tom Rockroads, Jr., Chairman
Northern Cheyenne Tribal Health Board
P.O. Box 6
Lame Deer, Montana 59043

Dear Mr. Rockroads:

We are enclosing a proposal for funding the ambulance and patient transportation system for the Northern Cheyenne Reservation. The enclosure represents our counter-proposal to the one you submitted in January 1981.

The proposal represents the funding that Indian Health Service (IHS) is currently providing to you. It is a combination of funds from Clinical Services, Tribal Programs, and Contract Health Services. There are no additional funds available to supplement the identified funding shown in the attached proposal. The proposal does contain several options to be considered in expanding the basic program using additional CHR's and/or volunteers. We suggest that you work closely with the Service Unit Director in reviewing these options and in implementing any of the options.

Sincerely yours,

for J. R. Smith
Director, Billings Area
Indian Health Service

Enclosures

Option I

Attachment I

Assuming 8 CHR's with Volunteers & Director

	S	M	T	W	T	F	S
	24	X	X	24	X	X	24
	24	X	X	24	X	X	24
	24	X	X	24	X	X	24
	X	24	X	X	24	X	X
	X	24	X	X	24	X	X
	X	X	24	X	X	24	X
	X	X	24	X	X	24	X
	X	X	X	X	X	X	X
	OCV	OCV	OCV	OCV	OCV	OCV	OCV
	X	OCV	OCV	X	OCV	OCV	X
rector	X	8	8	8	8	8	X
Driver	X	8	8	8	8	8	X

Minimum of two EMT's on DUTY AT ALL TIMES with three on weekends supplemented by on-call volunteers to have two crews available when necessary.

Director will take EMT call during his tour of duty.

The EMT will man dispatch when not on call. When all are on call, dispatch will need to be transferred to IHS/Police/?

The one driver will provide transfer service during his tour of duty.

CODE

On Duty 24 Hours - 24
On Duty 8 Hours - 8
Volunteer On Call - OCV
Off Duty - X

Option II

Attachment II

Assuming 8 CHR's and 4 CETA/Other Employees
and Director

	S	M	T	W	T	F	S
	24	X	X	24	X	X	24
	24	X	X	24	X	X	24
	24	X	X	24	X	X	24
	24	X	X	24	X	X	24
	X	24	X	X	24	X	X
	X	24	X	X	24	X	X
	X	24	X	X	24	X	X
	X	24	X	X	24	X	X
	X	X	24	X	X	24	X
	X	X	24	X	X	24	X
	X	X	24	X	X	24	X
	X	X	24	X	X	24	X
ector	X	8	8	8	8	8	X

One of four on duty EMT assigned to transfer of patients (non-ambulance) during the work week; M - F, 8:00 - 5:00; with director available during this time for maning second ambulance when needed.

No separate dispatch. EMT will man telephones. When second crew is in service, dispatch will go to IHS/Police/? of ten work hours.

CODE

On Duty 24 hours - 24

On Duty 8 hours - 8

Off Duty - X

Option III

Attachment III

Four Full Time Employees

S	M	T	W	T	F	S
8A	X	X	8A	8A	8A	8A
8A	8A	X	X	8A	8A	8A
8B	8B	8B	X	X	8B	8B
8B	8B	8B	X	X	X	8B
X	OCVW	OCVW	OCVW	OCVW	X	X
X	OCVW	OCVW	OCVW	OCVW	X	X
OCVWE	X	X	X	X	OCVWE	OCVWE
OCVWE	X	X	X	X	OCVWE	OCVWE

ONE OF FOUR DESIGNATED AS DIRECTOR

CODE

OCVW On call volunteer weekdays
4 nights on call
4:30 p.m. to 8:00 a.m.
Monday thru Thursday night
100 per week X 2 = $200 a week

OCVWE On call volunteers - weekends
4:30 p.m. Friday nights
through 8:00 a.m. Monday
$100 per weekend X 2 = $200 a week

8A - 8:00 - 5:00

8B - 8:00 - 5:00 except Friday, Saturday, Sunday from 4:00 p.m. to 12:00 midnight

8A & 8B Rotate late weekend
Shift each weekend

Option IV

Attachment IV

Assuming Seven Full Time Employees

	S	M	T	W	T	F	S
	24	X	X	24	X	X	24
	24	X	X	24	X	X	24
	X	24	X	X	24	X	X
	X	24	X	X	24	X	X
	X	X	24	X	X	24	X
	X	X	24	X	X	24	X
	X	X	X	X	X	X	X
Driver	X	8	8	8	8	8	X
	OCV	OCV	OCV	OCV	OCV	OCV	OCV
	OCV	OCV	OCV	OCV	OCV	OCV	OCV

No full time Director

No Secretary

Minimum of two EMT's on DUTY AT ALL TIMES supplemented by on-call volunteers to have two crews available when necessary.

Director will take EMT call during his tour of duty.

The EMT will man dispatch when not on call. When all are on call, dispatch will need to be transferred to IHS/Police/?

The one driver will provide transfer service during his tour of duty.

CODE

On Duty 24 Hours - 24
On Duty 8 Hours - 8
Volunteer On Call - OCV
Off Duty - X

Attachment V

Origin and Destination of Northern Cheyenne Ambulance Runs January, February, & March 1980

Local Runs (In and around Lame Deer to Lame Deer Clinic)	32
Busby to Lame Deer Clinic	6
Birney to Lame Deer Clinic	1
Ashland to Lame Deer Clinic	8
Local/Lame Deer Clinic/Crow	6
Local/Lame Deer Clinic/Billings	2
Ashland/Lame Deer Clinic/Billings	1
Lame Deer Clinic to Billings	4
Lame Deer Clinic to Crow	7
Lame Deer Clinic to Miles City	1
Lame Deer Clinic to Forsyth	1
Birney/Lame Deer Clinic/Crow	1
TOTAL:	69

The above data would indicate that 46.3% of all runs are in Lame Deer or within a ten mile area from Lame Deer. About 32% of all runs require transfers to sights off the reservation; i.e., Crow, Billings, Miles City, Forsyth. Only 13% of all runs go to Billings, Miles City, or Forsyth (about 3 a month).

There were an average of 2 runs a month to Busby; less than one a month to Birney, and about three a month to Ashland.

Attachment VI

Northern Cheyenne Ambulance Calls Per Day - Jan., Feb., & March 1980

Month	# of Days No Calls	# of Days (1) Call	# of Days (2) Calls	# of Days (3) or more Calls
January	16	9	3	3 1/
February	17	7	4	1 2/
March	13	9	2	7 3/
TOTAL	46	25	9	11

During these three months, 50.5% of the days there were no calls, 27.5% of the days there was one call, 10.0% of the days there were two calls, and only 12.1% of the days there were three or more calls. There were no days where there were more than three different incidents in a single day.

In only three of the twenty multiple call days were the incidents all outside Lame Deer. The other seventeen incidents, one or more of the calls were local.

1/ 1/1/80 - Three different incidents; one sent to Crow Agency - shown as four calls.

2/ 2/23/80 - Two different incidents: one sent to Crow Agency - shown as three calls.

3/ 3/10/80 - Three incidents - counted as four calls.
3/14/80 - Two incidents - counted as three calls.
3/22/80 - Three incidents - counted as four calls.
3/23/80 - One accident - counted as three calls.
3/24/80 - Three incidents - counted as four calls.

NORTHERN CHEYENNE BOARD OF HEALTH

P.O. BOX 6
LAME DEER, MONTANA 59043
(406) 477-6284

March 31, 1981

Mr. J.R. Smith, Director
Billings Area Office
Indian Health Service
P.O. Box 2143
Billings, Montana 59103

Dear Mr. Smith:

We have received the counter-proposal for Ambulance Service prepared by your office.

The Northern Cheyenne Board of Health is presently reviewing the options and a decision should be forth coming.

In reviewing the document there was some question on the accuracy of the figures reflected in the attachment VII. We therefore researched our files and have come up with the attached figures.

The information for the figures in the counter proposal and our attached documents both come from data from the daily trip reports on file here. The counter proposal data was based on trip reports that required additional man power and/or were serious enough to require more definitive care techniques. This information was submitted to the Service Unit but did not reflect the total call load.

If the options in the counter-proposal were based on the data supplied by the Service Unit it might be interesting if it was revised to include our figures.

If you have any questions feel free to call me at 477-6722.

Sincerely,

David Means

David Means, Director
Tribal Health Department

cc: Files ✓
BOH
Service Unit Director
Tom King, Ambulance Service

"PURSUING QUALITY HEALTH FOR THE NORTHERN CHEYENNE PEOPLE."

Attachment I

Month	# of days no calls	# of days 1 call	# of days 2 calls	# of days 3 or more calls
January	3	6	7	15
February	4	5	5	15
March	1	5	6	19
	8	16	18	48

* January 1	12 calls	February 1	4 calls	March 4	7 calls
January 2	12 calls	February 2	10 calls	March 5	4 calls
January 3	4 calls	February 3	7 calls	March 7	6 calls
January 5	8 calls	February 9	4 calls	March 10	8 calls
January 8	7 calls	February 10	6 calls	March 11	6 calls
January 9	6 calls	February 11	4 calls	March 14	8 calls
January 11	4 calls	February 18	7 calls	March 16	7 calls
January 12	5 calls	February 23	6 calls	March 18	4 calls
January 18	6 calls	February 26	5 calls	March 22	5 calls
January 20	6 calls	February 27	5 calls	March 23	6 calls
		February 29	6 calls	March 24	6 calls
				March 28	7 calls
				March 29	5 calls

The above figures represent total runs for the three months based on the trip reports. Included in the figures are all cancelled calls and all incidents in which there was more than one trip report used.

Trip reports are used for each incident when a patient is taken to the nearest medical facility. If the patient is referred on to another facility a new trip report is done to reflect what happened while enroute to that facility.

* Shows the number of days when more than three trip reports were used and how many in those days.

The figures show that there were 9% of no calls 18% of 1 call 20% of 2 calls and 53% of 3 or more calls.

Attachment II

Month	# of days no calls	# of days 1 call	# of days 2 calls	# of days 3 calls or more
January	3	7	9	12
February	4	6	4	15
March	1	6	8	16
	8	19	21	43

* January 1	9 calls	February 1	4 calls	March 4	7 calls
January 2	9 calls	February 2	6 calls	March 7	4 calls
January 3	4 calls	February 3	6 calls	March 10	6 calls
January 4	4 calls	February 9	4 calls	March 11	5 calls
January 5	6 calls	February 10	6 calls	March 14	4 calls
January 8	7 calls	February 18	6 calls	March 16	6 calls
January 9	5 calls	February 23	4 calls.	March 18	4 calls
January 11	4 calls	February 26	4 calls	March 22	4 calls
January 12	5 calls	February 27	4 calls	March 23	6 calls
January 18	5 calls	February 29	5 calls	March 24	4 calls
January 20	6 calls			March 28	6 calls
				March 29	5 calls

The above figures are based upon the Montana State Trip Report forms for the three months. The number of calls with more than one incident are included as one call. For example if there was a car wreck with 3 patients that is reflected as one call or when a patient is picked up locally and transported to the clinic and then to Crow/Billings this is also reflected as one call. Also includes all cancelled calls.

* Shows the number of calls above 3 calls and how many.

The figures show that there were 9% of no calls 21% of 1 calls 23% of 2 calls and 43% of 3 or more calls.

Attachment III

TYPES OF AMBULANCE CALLS OR RUNS

January to December 1980 (12 month period)

MONTH	CHRONIC OR ILLNESS	PSYCHO RELATED	O.B.	M.V.A.	DOMESTIC	TRANSFER STRETCHER	OTHER	C. CALLS	D.O.A.	TOTAL	NO. ALCOHOL RELATED
Jan.	38	2	5	--	5	10	22	10	---	92	30
Feb.	49	2	4	2	8	6	13	15	---	99	14
Mar.	35	---	10	14	6	4	28	13	---	110	39
April	44	---	10	--	9	2	19	6	---	90	20
May	53	1	4	28	12	10	27	13	---	148	40
June	46	--	7	16	14	1	36	17	---	137	40
July	44	--	9	14	29	2	32	10	---	140	22
Aug.	35	1	7	12	21	7	24	10	2	119	31
Sept.	33		7	2	12	3	23	13	1	94	14
Oct.	57	1	5	32	9	1	23	27	2	157	39
Nov.	28	--	2	4	7	5	19	13	---	78	23
Dec.	52	1	4	8	14	3	18	10	2	112	35
Total	514	8	74	132	146	54	284	157	7	1,376	347

The above table shows that there was 1,376 total calls or ambulance runs from the Emergency Ambulance Technicians Service Unit in the year 1980. Out of 1,376 calls 157 of these were cancelled leaving us with 1,219 valid runs. 357 of the runs were alcohol related giving us a percentage of 25.2 alcohol related cases and 74.8 non-alcholic. The average run per day is 3.7 or 3 to 4 runs each day.

*M.V.A. , Motor Vehicle Accidents, D.O.A. , Dead on Arrival, O.B.,Obstetrics, Psycho., Psychological, C calls, Cancelled calls.

Charlene lden, March 13, 1981

NORTHERN CHEYENNE BOARD OF HEALTH

P.O. BOX 6
LAME DEER, MONTANA 59043
(406) 477-6284

June 30, 1981

Mr. J.R. Smith, Director
Indian Health Service
Billings Area Office
P.O. Box 2143
Billings, Montana

Dear Mr. Smith:

This letter is in reference to the Counter Proposal submitted by your office to the Northern Cheyenne Board of Health dated March 16, 1981.

On June 30, 1981 at a Special Board of Health meeting a motion was passed by the Board of Health to reject the options proposed in the afore mentioned document.

The rationale behind the Board of Health's decision is that they feel that the existing resources presented in the Counter Proposal already are being fully utilized in doing thier present duties.

If you have any questions feel free to call me at 477-6722.

Sincerely,

David A. Means, Director
Northern Cheyenne Tribal Health Department

cc: files
Board of Health
Helbent Frazier-Service Unit Director

"PURSUING QUALITY HEALTH FOR THE NORTHERN CHEYENNE PEOPLE"

NORTHERN CHEYENNE BOARD OF HEALTH

P.O. BOX 6
LAME DEER, MONTANA 59043
(406) 477-6284

RECEIVED
OCT 26 1981
PHS Indian Health Center
Lame Deer, MT 59043

October 14, 1981

Mr. Helbent L. Frazier
Service Unit Director
Northern Cheyenne
Community Health Center
Lame Deer, MT. 59043

Dear Mr. Frazier:

As of January 30, 1981, the contract between the Indian Health Service and the Northern Cheyenne Board of Health was not renewed.

A proposal that was submitted by the Board of Health for $133,260.00 for fiscal year 81 was denied.

But, on March 16, 1981, the Billings Area Office submitted a counter proposal to the Health Board with their recommendations on how we could reallocate our present resources to continue operating.

On February 27, 1981, the Lame Deer Service Unit CMC conducted a study on what the Ambulance Service could possibly recover going to a billing system. Based on this study and a resolution from the Board of Health to bill for all services provided to Indian Health Service recipients.

We are submitting this bill to the Indian Health Service for services provided from February 1, 1981 to September 20, 1981 and we will continue to submit invoices for services on a bi-monthly or monthly basis.

In this bill attached we have excluded all medicaid, medicare and non-beneficiary patients, being that the CHR positions are under contract, we have made adjustments so IHS would not be paying twice for the same service.

The Northern Cheyenne Board of Health is requesting that the Indian Health Service consider this a bill and request payment.

If you have any questions concerning this bill please contact Mr. David Means.

This action was passed by the Northern Cheyenne Board of Health in a motion form on October 1, 1981.

Sincerely,

Tom Rockroads, Jr.
Chairman

"PURSUING QUALITY HEALTH FOR THE NORTHERN CHEYENNE PEOPLE."

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION

LAME DEER, MONTANA 59043

December 8, 1981

RECEIVED

DEC 11 1981

NORTHERN CHEYENNE
TRIBAL HEALTH DEPT.

Mr. Tom Rockroads, Jr., Chairman
Northern Cheyenne Board of Health
P.O. Box 6
Lame Deer, Montana 59043

Dear Mr. Rockroads:

Enclosed are returned invoices and attachments requesting payment for Ambulance Services in the amount of $35,337.04 for the period of February 1, 1981 to September 30, 1981 and Ambulance Service for month of October 1981.

I regret to inform you our position on further support of the ambulance service system on the Northern Cheyenne Reservation remains unchanged. We are already supporting the system at the rate of approximately $110,000 per year and cannot commit any additional funds to the Northern Cheyenne Reservation for ambulance services. With the decrease in our appropriations, we cannot foresee any possibility that we will ever be able to provide additional resources to the ambulance system. The Northern Cheyenne Board of Health will have to plan the continuation of the ambulance system based on current level of support from Indian Health Service.

The Northern Cheyenne Ambulance Services personnel are to be commended in the manner in which they continue operating the ambulance program in view of substantial cut-backs from previous resources.

Our service unit staff will continue to support the ambulance service and its endeavors in meeting a vital need to people on the Northern Cheyenne Reservation.

Sincerely,

Helbent L. Frazier, Service Unit
Director, Northern Cheyenne
Health Center

NORTHERN CHEYENNE BOARD OF HEALTH

P.O. BOX 6
LAME DEER, MONTANA 59043
(406) 477-6284

RESOLUTION NO. (81)

A RESOLUTION OF THE NORTHERN CHEYENNE BOARD OF HEALTH REQUESTING IHS TO INCLUDE TRIBAL REPRESENTATIVES IN THEIR RECOMMENDATIONS TO CONGRESS ON IHS BUDGET CUTS.

WHEREAS, the Northern Cheyenne Board of Health is charged with the responsibility of taking an active lead in assuring quality health care for every Northern Cheyenne; and

WHEREAS, presently the Northern Cheyenne Board of Health and its programs have received cuts in their program budgets; and

WHEREAS, there is further proposed budts in IHS budget for FY 82 and these cuts will affect the health care of the Northern Cheyenne people; now

THEREFORE BE IT RESOLVED that if additional budget cuts for FY 82 become a reality that there be participation by Tribes in the recommendations made by IHS; and

BE IT FURTHER RESOLVED that Northern Cheyenne Board of Health requests that said tribal participation be as follows
Headquarters level - NTCA, NIHB, NCAI and any other national Indian organization
Area level - Montana Indian Health Board

PASSED, ADOPTED AND APPROVED by the Northern Cheyenne Board of Health by (7) votes for passage and adoption and (0) votes against passaged and adoption this 8 day of October, 1981.

Tom Rockroads, Jr., Chairman
Northern Cheyenne Board of Health

ATTEST:

Henry Scalpcane
Henry Scalpcane, Secretary
Northern Cheyenne Board of Health

NOTED AND FORWARDED 10/30/81

PRESIDENT, NORTHERN CHEYENNE TRIBE

"PURSUING QUALITY HEALTH FOR THE NORTHERN CHEYENNE PEOPLE."

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

TO: Mary Ewing,
Director,
Community Health Representative Program

DATE: 10-16-81

FROM: Mary Dodson
Supervisor, Community Health Nursing

SUBJECT: Community Health Representative Program

Mary, the Cheyenne Women who work in the CHR program have been so much help to me in the 2 yrs and 3 mos that I've been here, I'm sure I could not have done my job without them. They have helped me to get to know the reservation, seen patients that I did not have time to see, and interpreted for me when I could not understand the old people. Furthermore, if it were not for the hard work of your workers, we would never have reached our goal in the immunization program. They have also helped with ours well Child clinics and Diabetic clinics. They are indispensable in the area of Communicable Diseases. None of these programs could exist without the help of the Community Health Representatives. Our program could not possibly fill the gaps left if any of your workers had to leave. A great many home-bound, elderly and sick people would suffer.

Mary Dodson, CHN

Service Unit Director, PHS Indian Health Center
Lame Deer, MT
Attention: Director, Community Health Representative
THROUGH: Acting Assistant Area Director Refer to: AUD
Patient Care Programs

S/ R.W. ARNOLD

Area Audiologist
Communication Disorders Office

Pat Rowland - CHR ENT

Communication Disorders Program works as an itinerant program. That is, the professional staff is available on the reservation approximately two to four times per month. This leaves a significant amount of time when persons with hearing problems, hearing aids or other types of ear disorders are without help. For effective functioning, this type of program requires assistance of an individual who is familiar with the people who are to obtain these services. This includes familiarity of the individual families or sociological conditions which may have an effect on the treatment of an individual case as well as an ability to understand and communicate with individuals in that particular area. Our experience in the Communication Disorders Program has been that the CHR plays a significant role in increasing the show-up rates for clinics and surgery, improving post-surgical follow-up, and eliminating problems related to hearing aid use. Ms. Rowland has been particularly successful in increasing patient contact, and patient follow-up on the Northern Cheyenne Reservation. It is presently the most successful program we have running on any of the reservations with which I am involved. Specifically, individual tasks of the CHR's would include the following:

1. Maintain regular office hours so that individuals needing service have regular access to batteries, hearing aid repairs, appointment request, and other service necessary on a full time basis.

2. Provide regular home visits and education for:

   a. correct hearing aid usage
   b. pre and post surgical counseling
   c. informing patients of potential danger of ear problems
   d. act as an intermediary between patient and ENT teams and explain test results or any questions that may arise.

3. Routinely review patient charts and day sheets so that appropriate persons can be scheduled.

4. Assist in hearing screening programs doing pure-tone audiometry and tympanometry under the supervision of the audiologist.

5. Participate in regular in-service training program developed especially for the ENT-CHR.

6. Participate in speciality clinics such as Developmental Assessment clinics and Cleft Palate clinics that will be developed for the Northern Cheyenne Reservation.

7. Maintain frequent and consistant contact with the ENT team to coordinate future schedules and determine the needs of the population.

Inclusion, the CHR's associated with the Communication Disorders Program provides valuable service both to the ENT team and the Native American population on the Northern Cheyenne Reservation. Certainly we do not anticipate any decrease in services through the reservation. We do, in fact, anticipate some increases in the type of services that Ms. Rowland could provide. As these increased services are developed, we will update this job description.

If we can be of any further assistance, please do not hesitate to contact us.

Glenn A. Hladek

Mr. MEANS. I would like to make two recommendations.

No. 1, the Northern Cheyenne Tribe would like to keep direct health delivery services from budget reductions, and it is our recommendation that the budget cuts be IHS program wide, giving authority to Indian Health Service to make cuts, hopefully at the headquarters and area levels, thus leaving out cuts at the local levels.

It has also come to our attention that tribal health boards and their departments are funded out of the budget line item, hospital and clinics, which puts us in direct competition with health care dollars. We recommend that health boards be funded out of the budget line item, program management, which provides administrative functions for the Billings area. Thank you.

Senator MELCHER. You recommend that the health boards do what?

Mr. MEANS. Area health boards and local health boards be funded out of program management line item within the IHS budget.

Senator MELCHER. Thank you very much, all of you.

I will submit for the record at this time, testimony of Caleb Shields, Assiniboine and Sioux Tribe, and testimony of Allen White Lightning, of the Standing Rock Sioux Tribe.

[The material follows. Testimony resumes on p. 147.]

PREPARED STATEMENT OF CALEB SHIELDS, TRIBAL COUNCILMAN, FORT PECK ASSINIBOINE AND SIOUX TRIBES, AND CHAIRMAN NCAI ALCOHOLISM COMMITTEE

Mr. Chairman and members of the committee: I am very pleased to appear before this committee to discuss the federal appropriations of the Indian Health Service and its subsequent Indian Alcoholism programs, which have been authorized appropriations under the Indian Health Care Improvement Act, Public Law 94-437, Title II, Section 201(c)(5).

The Indian Health Care Improvement Act, Public Law 94-137 gave the Indian Health Service (IHS) the responsibility for treatment and control of alcoholism among American Indians/Alaskan Natives. Therefore, in 1978 the Office of Alcoholism was established as a separate organizational detachment, within the Office of the Director of Indian Health Service. This subsequent legislation also stipulated that a transfer of "mature" American Indian/Alaskan Native alcoholism projects from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) could be carried out.

The House Committee on Interior and Insular Affairs in 1980, authorized appropriations for section 201(c)(5). This section of the Indian Health Care Improvement Act provides authorization for appropriations for Indian Alcoholism programs for which IHS has estimated a need of $15,237,000 for fiscal year 1981 in its justification of appropriations estimates before the Appropriations Committee. The Committee bill provides an authorization of $16,500,000 for fiscal year 1981 with fifteen percent increases for each year of the succeeding years. This amount takes into consideration that the Indian Alcoholism programs funded by IHS have been transferred to IHS from the National Institute of Alcohol Abuse and Alcoholism (NIAAA) after a sixth year of funding and have remained at the same level of funding since their inception at NIAAA, with the exception of $793,000 appropriated in fiscal year 1980 for program expansion and used for program transferred from NIAAA to IHS in fiscal year 1978 and 1979. (Indian Health Care Amendments of 1980, Senate, 96th Congress, 2nd session, report No. 96758, May 1980, p. 6-7).

There are two concerns that arise from this background information and the current reduction issue of Alcoholism program funding. The first concern is the loss of Indian Alcoholism projects which have been designated as "mature" (those projects which have reached the maximum authorized funding limit of six (6) year from NIAAA, thereby proving for over half a decade to NIAAA that they have been a viable project) and have to obtain funding from other sources. IHS was authorized to fund such "mature" projects and indeed they have funded such projects. In 1979, IHS has transferred eighty-eight (88) projects from NIAAA. In 1979 these eighty-eight transferred projects provided service to approximately 57,000 persons.

The second concern is that of the clients now being served by the IHS and NIAAA "mature" Indian Alcoholism projects. Indian alcoholism is a complex syndrome that affects other social problems such as crime, delinquency, poverty and underemployment, without alcoholism facilities these social problems can only be further compounded. The Indian Health Clinics which have a primary purpose of providing direct health services will be left to contend with these additional clients on previously estimated budget (which do not take this cliental into account).

In an analysis of the current inpatient and outpatient of the Aberdeen and the Bemidji health service areas, there already is an increase in usage of hospital facilities. The Bemidji area has seen a +16.7 percent increase in admissions between October 1980 and September 1981. While the Aberdeen service area hospitals have experienced a +1.2 percent increase in admissions between October 1980 and June 1981. The outpatient visits have also increased for both Aberdeen (+3.8 percent October 1980 to June 1981) and Bemidji (6.3 percent October 1980 to September 1981) service areas. Discussion with tribal police reveals that the majority of deaths (greater than 90 percent) in the 18–22-year-old range are alcohol or drug related. We have no real statistics as to whether or not a good alcoholism program or education project could prevent these deaths.

In those Indian communities where no IHS hospital exists and only an alcoholism facility exists (which could close without further funding) the Indian alcoholic without any care facility to go to could be considered a drunk and jailed rather than an alcoholic and hospitalized.

I therefore recommend:

(1) alcoholism staff and facilities be incorporated into a line item of IHS so that "mature programs" continue to be funded.

(2) a research project to study the efficiency of the alcoholism programs be funded and undertaken.

PREPARED STATEMENT OF ALLEN WHITE LIGHTNING, TRIBAL COUNCIL, STANDING ROCK SIOUX TRIBE

I am here on behalf of the Standing Rock Sioux Tribe. We wish to present to the Committee brief but important issues regarding the operations of the Indian Public Health Service, IPHS. Virtually all of these issues center on the impact of fiscal 1982 budget reductions. The issues are:

1. For several years and today the Standing Rock Service Unit (hospital) has been without assigned medical officers. As one reviews the record it becomes clear that every service unit in our region, and there are 24 units, have had and today are staffed with assigned medical officers. Standing Rock remains the only service unit with *All* of its medical positions vacant (see attachment 1).

2. Standing Rock's IPHS discretionary health programs have, relative to all other tribes in our region, been marginally funded. Given this relative funding imbalance, percentage budget cuts impact severely on our people. The practice of disproportionate funding should be reviewed by the Committee (see attachment 2).

3. We have reviewed the salary and benefit schedules of the Aberdeen Area Office. We have concluded that they are significantly out of proportion with regard to the services performed. Your Committee should undertake an investigation and examination with respect to benefit-costs of inflated administrative overhead which we see saturating the IPHS Area and Central offices (see attachment 3).

4. Finally, members of the Committee, we appreciate the opportunity to comment on specific problems. Our comments are:

A. The Community Health Representative Program, CHR, is a vital service to our isolated Indian communities. Under conditions of almost total income dependency, this program in many instances is the only health service safety net program which reaches the people. To withdraw support and funding of this critical need is unconscionable (see attachment 4).

B. Alcoholism has been identified by study upon study as the number one cause of social pathology on Standing Rock. The IPHS treats the problem of alcoholism as its very last priority.

On behalf of Pat McLaughlin, Tribal Chairman of the Standing Rock Sioux Tribe, I thank the Committee for this opportunity to appear here today and present our testimony.

ABERDEEN AREA INDIAN HEALTH SERVICE

JULY 1981

KEY:
- (S) Scholarship
- (CD) Clinical Director
- (CO) Commissioned Officer
- (GS) Civil Serv.
- (EOD) Enter on duty date
- (FNP) Family Nurse Practitioner

LOCATION	POSITION	INCUMBENT	PROSPECT	PA/CHM
Aberdeen, SD	Area Director	Eleanore A. Robertson, Area Director		
Aberdeen, SD	Medical Officer (Adm.)	Rupert O. Clark, MD, (IM), (FP), (CO) Chief, Medical Officer/Deputy Director		
Aberdeen, SD	Medical Officer	Thomas Milroy, MD, (GS), (OBGYN) (Maternal & Child Health)		
Aberdeen, SD	Medical Officer (Adm.)	Esther Anderson, MD, (GS), (PED) Chief, Office of Medical Care Evaluation		
Aberdeen, SD	Medical Officer	Lois Steele, MD, (CO) (Duty station - Grand Forks, ND)		
Aberdeen, SD	Medical Officer (Adm.)	VACANT (Deputy Chief, Office of Quality Assurance/Medical Care Evaluation)		
Belcourt, ND	Medical Officer	Lyle Best, MD, (CO), (CD), (FP)		
Belcourt, ND	Medical Officer	Visitacion Ramirez, MD, (GS), (FP)		
Belcourt, ND	Medical Officer	Peter Funk, MD, (CO), (S)		
Belcourt, ND	Medical Officer	Hans Hager, MD, (S), (CO)		
Belcourt, ND	Medical Officer	Karen Shepherd, DO, (CO), (S)		Dixie Bluestone (PA)
Belcourt, ND	Medical Officer	Vacant	Michael Bennish, MD (PED)	
Belcourt, ND	Service Unit Director	Clarence Frederick		
Eagle Butte, SD	Medical Officer	Nancy O'Conner, MD, (CO), (FP)		
Eagle Butte, SD	Medical Officer	Virginia Updegraff, MD, (CO)		
Eagle Butte, SD	Medical Officer	Richard Updegraff, MD, (CO), (FP), (CD)		
Eagle Butte, SD	Medical Officer	Vacant	Milton Levine, D.O.	
Eagle Butte, SD	Service Unit Director	Don Annis (Acting)		
Fort Yates, ND	Medical Officer	Vacant	Mark Jackson, MD, (S)	Patricia Bloom (FNP)
Fort Yates, ND	Medical Officer	Vacant		
Fort Yates, ND	Medical Officer	Vacant		
Fort Yates, ND	Medical Officer	Vacant		
Fort Yates, ND	Service Unit Director	T. Charles Tonemah		
McLaughlin, SD	Medical Officer	Vacant	Robert Morrow, MD, (PED) 8/81	
Pine Ridge, SD	Medical Officer	Charles Mock, MD, (S), (CO)		Barb Criss (Midwife)
Pine Ridge, SD	Medical Officer	Chris Yeakel, MD, (S), (CO)		
Pine Ridge, SD	Medical Officer	William Moshofsky, MD, (S), (CO)		
Pine Ridge, SD	Medical Officer	Vona Wright, MD, (S), (GS)	David Vogt, DO, (S) 8/81	
Pine Ridge, SD	Medical Officer	Tim McQuinn, MD, (GS), (S), (CD)		Joann Rodreques (PA)
Pine Ridge, SD	Medical Officer	Ron Forgey, DO, (S), (CO) Lv. 8/81		
Pine Ridge, SD	Medical Officer	Vacant		Timothy Payne (Kyle)
Pine Ridge, SD	Service Unit Director	Terrance Pourier		
Rapid City, SD	Medical Officer	Ray Wong, MD, (CO), (IM), (CD)		Maria Ramos, (PA)
Rapid City, SD	Medical Officer	Jack Markusfeld, MD, (CO), (S), (IM)		James Chapman, (PA)
Rapid City, SD	Medical Officer	Manuel Guzman, MD, (GS)		
Rapid City, SD	Medical Officer	Fredric M. Birch, MD, (CO), (S), (IM)		
Rapid City, SD	Service Unit Director	Q. Thomas Novinger, MD, (CO), (S), (PED) (Acting) Lv. 7/12/81		
Rapid City, SD	Medical Officer	Robert Williams, MD, (GS), (PSYCH)		

ATTACHMENT 1

ABERDEEN AREA INDIAN HEALTH SERVICE

JULY 1981

LOCATION	POSITION	INCUMBENT	PROSPECT	PA/CHM
Rosebud, SD	Medical Officer	Lucy Reifel, MD, (S), (GS), (PED), (IM)		Vacant (PA)
Rosebud, SD	Medical Officer	Wayne Foster, MD, (GS)		
Rosebud, SD	Medical Officer	Maude Karlsson, MD, (PED) (Temp.- Potential permanent)		
Rosebud, SD	Medical Officer	Vacant		
Rosebud, SD	Medical Officer	Vacant	John Lee, MD,	
Rosebud, SD	Medical Officer	Vacant	Walter Pavlin, MD	
Rosebud, SD	Medical Officer	Lawrence Runke, MD (SURG) (Temp. 2 mos. - Potential permanent)		
Rosebud, SD	Service Unit Director	John Gobert		
Sisseton, SD	Medical Officer	Bertrand Duncan, MD, (GS), (CD)		
Sisseton, SD	Medical Officer	Vacant		
Sisseton, SD	Medical Officer	Vacant		
Sisseton, SD	Service Unit Director	Hildreth Venegas		
Wagner, SD	Medical Officer	Mark Butterbrodt, MD, (S) (PED), (CO), (CD)		Thelma Selvyn, (PA)
Wagner, SD	Medical Officer	Gary Bubak, MD, (S), (IM), (GS)		
Wagner, SD	Medical Officer	Larry Banta, MD, (S), (CO)		
Wagner, SD	Service Unit Director	Cliff Johnson		
Winnebago, NB	Medical Officer	John Logan, MD, (S), (GS) Lv. 8/30/81		Tonia Keller, (PA)
Winnebago, NB	Medical Officer	James Knister, MD, (S), (CO)		
Winnebago, NB	Medical Officer	Kathie McAlpine, MD, (CO), (S)		
Winnebago, NB	Medical Officer	David Cattau, MD, (C), (CO)	Gregg Erickson, MD, (CO) 9/81	
Winnebago, NB	Service Unit Director	Mike Wood (Acting)		
Macy, NB	Medical Officer	Eddie Nicholas, MD, (IM) (Tribal Contract)		
Macy, NB	Medical Officer	Nathan Simon, MD, (OBGYN) (Tribal Contract)		
Macy, NB	Project Officer	James Cournoyer (Duty Station - Winnebago)		
Fort Totten, ND	Medical Officer	Vacant	Patricia Greve, MD, (S)	Tim Nelms, (PA)
Fort Totten, ND	Medical Officer	Steve Lokke, MD, (GS)	Andre Huffmire, MD	
Fort Totten, ND	Service Unit Director	Loretta Bad Heart Bull		
Newtown, ND	Medical Officer	Roger Greyeyes, MD, (GS), (CD)		Prentice Harrison, (PA) (Twin Buttes)
Newtown, ND	Medical Officer	Vacant		
Newtown, ND	Service Unit Director	Mary Lou Stanton		
Chamberlain, SD	Medical Officer	Michael Crandell, MD, (GS), (CD), (S)		Vacant, (PA) (Lower Brule)
Chamberlain, SD	Medical Officer	Charles Kramer, MD, (GS)		
Chamberlain, SD	Medical Officer	AnnaMaria Kosa, MD, (GS), (SURG)		
Chamberlain, SD	Service Unit Director	Michael Crandell, MD (Acting)		

BEMIJI AREA INDIAN HEALTH SERVICE

JULY 1981

LOCATION	POSITION	INCUMBENT	PROSPECT	PA/CHM
Bemidji Prgm. Area	Medical Officer	James Fett, MD, (CO), (IM), (CMO)		
Bemidji Prgm. Area	Program Director	John Buckanaga		
Cass Lake, MN	Medical Officer	Stephen Brabeck, MD, (S), (GS), (IM), (CD)		
Cass Lake, MN	Medical Officer	Thomas Martin, MD, (S), (PED), (CO)		
Cass Lake, MN	Medical Officer	David Bryce, MD, (S), (IM), (CO)		
Cass Lake, MN	Medical Officer	Linda Mulka, MD, (CO), (FP)		
Cass Lake, MN	Medical Officer	Joseph Hartman, DO, (FP), (CO) Lv. 8/81		
Cass Lake, MN	Service Unit Director	Jerry Fagerstrom		
Red Lake, MN	Medical Officer	Dennis G. Sollom, MD, (S), (CO)		
Red Lake, MN	Medical Officer	Steve Haugen, MD, (S), (CO)		
Red Lake, MN	Medical Officer	Michael David Lauter, MD, (FP), (S), (CO)		
Red Lake, MN	Medical Officer	John Hussey, MD (S), (CO), (CD), (FP)		
Red Lake, MN	Medical Officer	Randall Barnhart, MD, (IM), (GS)		
Red Lake, MN	Service Unit Director	Ethel Pemberton		
White Earth, MN	Medical Officer	Helen Anderson, MD (S), (CO)		
White Earth, MN	Medical Officer	Peter Vandermark, MD (S), (CD), (CO)		
White Earth, MN	Service Unit Director	Franklin Heisler		
Mille Lacs, MN	Medical Officer (Tribal)	Tribal Employee		Gertrude Lambert (FNP)
Kincheloe, MI	Medical Officer	Joan Rubenstein, MD, (CO), (FP)		
Kincheloe, MI	Medical Officer	Alex Sheriff, MD, (CO), (FP)		
Kincheloe, MI	Service Unit Director	Arlene Marshall		
Menominee, WI	Medical Officer	Donald L. Lum, MD, (S), (CO), (FP)		
Menominee, WI	Medical Officer	Filled by a contract physician		
Oneida, WI	Medical Officer (IHS)	John Kiser, MD, (S), (CO)		
Oneida, WI	Medical Officer (Tribal)	John O'Brien, MD, (S), (GS)		
Stckbrdg-Mun, WI	Medical Officer	Jed Magen, MD, (S), (CO)		
Lac Court. Or., WI				
Lac du Flam, WI	Medical Officer	Steve Charapata, MD, (S), (GS)		Clarence Graether (FNP)

ATTACHMENT 2

RESOLUTION

No. 338-81

WHEREAS, the Standing Rock Sioux Tribe is an unincorporated Tribe of Indians, having accepted the Indian Reorganization Act of June 18, 1934, and the recognized governing body of the Tribe is known as the Standing Rock Sioux Tribal Council, and

WHEREAS, the Standing Rock Sioux Tribal Council, pursuant to the Constitution of the Standing Rock Sioux Tribe, Article IV, Section 1(o), is empowered to safeguard and promote and peace, morals, physical and general welfare of the members of the Tribe, and

WHEREAS, the Standing Rock Sioux Tribal Council has been made aware, through its Health, Education, and Welfare Committee, of alleged discrepancies in medical practices at the Indian Health Service Hospital, Fort Yates, North Dakota, charging IHS staff with the compromising of patients' lives, misdiagnoses, etc., and

WHEREAS, the Tribal Council has determined that the best means possible of resolving the allegations is to call for the assistance of the North and South Dakota Congressional delegation to conduct an investigation of the Service Unit Hospital in Fort Yates, North Dakota.

NOW THEREFORE BE IT RESOLVED, that the Standing Rock Sioux Tribal Council hereby calls upon the Congressional Delegations of both North and South Dakota to initiate action to conduct a Congressional investigation into the allegations made.

BE IT FURTHER RESOLVED, that the Chairman and Secretary of the Tribal Council be authorized and instructed to sign this resolution for and on behalf of the Standing Rock Sioux Tribe.

CERTIFICATION

We, the undersigned, Chairman and Secretary of the Tribal Council of the Standing Rock Sioux Tribe, hereby certify that the Tribal Council is composed of 15 members, of whom 13, constituting a quorum, were present at a meeting thereof, duly and regularly called, noticed, convened, and held on the 16th day of October, 1981, that the foregoing resolution was duly adopted by the affirmative vote of 10 members, with 0 opposing, and with 3 not voting. The Chairman's vote is not required except in case of a tie.

Dated this 20th day of October, 1981.

Pat McLaughlin, Chairman
Standing Rock Sioux Tribal Council

ATTEST:

Lilli Whitetemple

Lillian White Temple, Secretary
Standing Rock Sioux Tribal Council

(OFFICIAL SEAL)

SALARY AND BENEFIT SCHEDULE--TOTAL AREA ATTACHMENT 3

ABERDEEN AREA OFFICE, ABERDEEN, SD

Office of the Area Director

03450001	AB0101	Health Care Adm.	GS	0601	15	Robertson	Eleanore A.	$44,547.00
03450001	AB0102	Deputy Area Director	CC	0602	06.	Clark	Rupert	$53,713.00
03450001	AB0103	Hosp. Admin. Officer	GS	0670	15	Allery	Alan J.	$46,032.00
03450001	AB0104	Staff Assistant	GS	0301	09	Kelly	Joan K.	$22,925.00
03450001	AB0106	Computer Programmer	GS	0332	09	VACANT		
03450009	AB4113	Medical Officer	CC	0602	03	Steele	Lois F.	$32,583.00
03450009	AB9910	Public Health Adv. (Region VIII)	GS	0685	13	Parker	Gabe E.	$36,320.00
03450001	AB9801	EEO Specialist	GS	0160	13	Two Hawk	Webster	$32,048.00

Administrative Services

Property & Supply

03450005	AB1001	General Svcs. Officer	GS	0310	14	Longbrake	Jayme M.	$41,657.00
03450005	AB1003	Staff Assistant	GS	0301	07	Fordham	Linda A.	$18,735.00
03450007	AB1010	Contract Adm.	GS	1102	13	Stein	Merlin O.	$35,252.00
03450007	AB5118	Contract Adm.	GS	1102	12	Vallie	Ronald J.	$29,645.00
03450007	AB1011	Contract Spec.	GS	1102	12	Thompson	Kenneth L.	$31,441.00
03450030	AB5602	Grants Mgmt. Spec.	GS	1101	09	Giroux	Patrick	$19,275.00
03450007	AB5119	Contract Specialist	GS	1102	09	LaVallie	Karen M.	$13,565.00
03450007	AB1002	Contract Specialist	GS	1102	11	Shortbull	Elizabeth G.	$23,236.00
03450007	AB5124	Procurement Clerk (Typ)	GS	1106	05	Craves	Bernita J.	$15,947.00
03450007	AB1013	Procurement Agent	GS	1102	09	Mills	Bernard	$18,585.00
03450007	AB1014	Procurement Agent	GS	1102	07	Sieler	Ronald J.	$15,193.00
03450007	AB1012	Contract Clerk (Typ)	GS	0301	03	Sanchez	Melinda	$ 9,766.00
03450007	AB5123	Contract Assistant	GS	1102	07	Swiftbird	Stella M.	$15,193.00
03450004	AB1004	Gen. Supply Spec.	GS	2001	12	VACANT		
35450004	AB1005	Gen. Supply Spec.	GS	2001	11	Sutten	Ronald W.	$27,736.00
03450004	AB1007	Supply Clerk	GS	2005	05	Drappeaux	Darryl R.	$12,266.00
03450004	AB1008	Clerk (Real Prop.)	GS	0301	06	Bourdon	Wiegert J.	$16,364.00
03450004	AB1006	Supply Mgmt. Rep.	GS	2003	09	Kuckelburg	Irvin P.	$23,545.00
03450004	AB1009	Supply Clerk (Typ)	GS	2005	05	Rush	Shavonne M.	$12,266.00

.50005	AB1015	Support Svcs. Supv.	GS	0342	09	Smith	Darel L.	$21,685.00
03450005	AB1016	Office Svcs. Clk. (Typ)	GS	0303	04	Donnell	Vernal	$ 9,766.00
03450005	AB9906	Clerk (Typ)	GS	0301	03	German	Ann L.	$10,092.00
03450005	AB1017	Laborer	WG	3502	02	Giroux	Claude	$14,040.00
Facilities Management								
03450014	AB0801	General Engineer	GS	0801	14	VACANT		
03450014	AB0803	Facilities Manager	GS	1640	12	Holman	Robert	$27,849.00
03450014	AB0802	Mechanical Engineer	GS	0830	12	VACANT		
03450015	AB4107	Eqip. Spec(Med.& Bio)	GS	1670	12	Bell	Wesley	$26,951.00
03450014	AB0804	Engineering Tech.	GS	0802	11	VACANT		
03450014	AB0805	Secretary (Steno)	GS	0318	05	Picotte	Ida C.	$14,311.00
03450015	AB4108	Bio-Medical Eng. Tech.	CC	0819	04	Rogers	Jerry	$32,749.00
03450015	AB4112	Bio-Medical Eng. Tech.	GS	0802	09	VACANT		
Financial Management								
03450002	AB0901	Financial Manager	GS	0505	14	Wasem	William E.	$45,443.00
03450002	AB0902	Ass't Financial Mgr.	GS	0505	13	Madrano	Daniel	$32,048.00
03450002	AB0903	Secretary (Steno)	GS	0318	05	VACANT		
03450002	AB9909	Claims Clerk	GS	0998	05	Richards	Lillian	$10,963.00
03450002	AB0904	Budget Officer	GS	0560	12	Wolff	Norma A.	$29,645.00
03450002	AB9909	Budget Analyst	GS	0560	09	Knarr	Betty L.	$18,585.00
03450002	AB0907	Supv. Acctg. Tech.	GS	0525	09	Bruers	Signe E.	$21,065.00
03450002	AB0909	Accounting Technician	GS	0525	04	Selzler	Theresa	$10,963.00
03450002	AB0912	Accounting Technician	GS	0525	05	Emmett	Sandra	$15,129.00
03450002	AB0906	Accounting Technician	GS	0525	05	Saul	Ramona	$13,034.00
03450002	AB0905	Accounting Technician	GS	0525	05	Joseph	Anita L.	$13,493.00
03450002	AB0910	Accounting Technician	GS	0525	07	Knudson	Mary Ann	$15,193.00
03450002	AB0911	Accounting Technician	GS	0525	07	Annis	Mary Lou	$15,193.00
03450002	AB0908	Accounting Technician	GS	0525	04	Youngbird	Renfer	$12,423.00
03450002	AB0913	Voucher Exam Supv.	GS	0540	07	Vallie	Norine P.	$18,229.00
03450002	AB0921	Lead Voucher Exam.	GS	0540	07	Poe	Ellie M.	$19,241.00
03450002	AB0918	Voucher Exam (Typ)	GS	0540	03	VACANT		
03450002	AB0914	Voucher Exam	GS	0540	06	Consor	Mary E.	$15,952.00
03450002	AB0915	Voucher Exam.	GS	0540	06	Schley	Geraldine E.	$17,320.00
03450002	AB0916	Voucher Exam.	GS	0540	06	Jangula	Darlene W.	$16,864.00
03450002	AB0917	Voucher Exam.	GS	0540	06	Barr	Margaret L.	$17,776.00
03450002	AB0919	Voucher Exam. (Typ)	GS	0540	06	Longbrake	Beverly A.	$14,128.00
03450002	AB1201	Voucher Exam.	GS	0540	04	Saul	Marcel J.	$11,693.00
03450002	AB0920	Voucher Exam.	GS	0540	05	Picotte	Raymond C.	$12,266.00

Personnel Management								
03450003	AB1101	Program Mgmt. Officer	GS	0340	14	Nielson	Rolland L.	$44,181.00
03450003	AB1102	Secretary (Typ)	GS	0318	05	Martin	Gail L.	$13,493.00
03450003	AB4102	Pers Staff Spec	GS	0212	12	White	Edward	$35,033.00
03450003	AB4105	Staff Assistant	GS	0303	05	Hoffman	Sharon M.	$14,584.00
03450003	AB4202	Pers Staff Spec	GS	0212	12	Gerry	Richard B.	$27,649.00
03450003	AB1106	Class & Wage Spec.	GS	0221	12	VACANT		
03450003	AB1108	Class & Wage Spec.	GS	0221	11	VACANT		
03450003	AB4103	Class & Wage Spec.	GS	0221	09	Lee	Donald W.	$18,585.00
03450003	AB4109	Supv. Pers. Mgmt. Spec.	GS	0201	13	Oge	Linda L.	$32,048.00
03450003	AB9807	Clerk-Typist	GS	0322	03	Ducheneaux	Nancy	$ 9,766.00
03450003	AB9803	Labor Mgmt & Empl. Rel. Specialist	GS	0230	12	Johnson	James C.	$35,033.00
03450003	AB4104	Empl. Dev. Spec.	GS	0235	12	O'Reilly	Robert D.	$29,645.00
03450003	AB9805	Empl. Dev. Spec.	GS	0235	11	Keoke	Betty B.	$24,736.00
03450003	AB1103	Supv Pers Staff Spec	GS	0202	12	Schultz	Wilbert G.	$35,033.00
03450003	AB9804	Pers. Staff. Spec.	GS	0212	11	Azure	David W.	$23,236.00
03450003	AB1104	Pers. Staff. Spec.	GS	0212	07	Bohling	Vina M.	$15,193.00
03450003	AB1105	Staffing Clerk (Typ)	GS	0203	03	Zephier	Kira	$ 9,766.00
03450003	AB1107	Pers. Mgmt. Spec.	GS	0201	07	Lanier	Lawrence N.	$15,193.00
03450003	AB4106	Personnel Clerk (Typ)	GS	0203	06	Woken	Virginia M.	$15,496.00
03450003	AB9806	Ind. Self-Det. Spec.	GS	0301	13	VACANT		
03450003	AB9808	Personnel Clerk (Typ)	GS	0203	04	Byington	Doris M.	$10,963.00
03450003	AB1109	Payroll Supv.	GS	0544	07	Docktor	Geri	$19,241.00
03450003	AB1111	Payroll Clerk	GS	0544	05	LeCompte	Barbara J.	$12,675.00
03450003	AB1110	Payroll Clerk	GS	0544	04	Archambeau	Francis	$11,693.00
Office of Environmental Health								
03450032	AB5101	Chief, OEH	CC	0688	06	Brackett	Perry	$46,709.00
03450032	AB5105	Chief, EHS Branch	CC	0688	05	Lashley	Floyd L.	$40,719.00
03453118	AB5106	Supv. Sanitarian	GS	0688	12	Gardner	Rodney	$26,734.00
03453118	AB5109	Instl Env Control Off	CC	0688	06	Lawler	James F.	$49,858.00
03453118	AB5107	Staff Sanitarian	CC	0819	04	Cohen	Steven	$28,105.00
03450032	AB5110	Staff Assistant	GS	0301	07	Hanson	Karen J.	$18,735.00
03453118	AB5108	Clerk-Typist	GS	0312	04	VACANT		
03450032	AB5104	Administrative Asst.	GS	0341	07	VACANT		

03450032	AB5103	Clerk-Steno	GS	0312	05	Hanson	Hildegarde	$14,720.00
03450032	AB5102	Administrative Officer	GS	0341	07	Stevens	Essimae	$16,205.00

Sanitary Facilities Construction

03450032	AB5111	Chief, SFC Branch	CC	0819	05	Hausken	Terrence O.	$34,082.00
03450032	AB5112	Deputy, Chief-SFC Br.	CC	0819	04	Pollard	Phillip E.	$31,077.00
03453117	AB5113	Environmental Engineer	GS	0819	12	Boulais	Charles O.	$27,849.00
03453117	AB5114	Supv. Environ. Engineer	GS	0819	13	Brown	Arnold	$32,048.00
03453117	AB5116	Staff Engineer	CC	0810	03	Pool	Thaddeous	$29,914.00
03453117	AB5117	Supv. Environ. Engineer	GS	0819	12	Jensen	Douglas	$32,474.00
03453117	AB5115	Civil Engr. Tech.	GS	0802	09	Bingham	Marvin R.	$19,205.00
03453117	AB5127	Staff Engr. (Hawaii)	CC	0819	03	Smith	Ernest D.	$23,270.40
03453117	AB5128	Staff Engineer	CC	0819	04	Vyff	Rodney	$29,495.00
03453117	AB5122	Staff Assistant	GS	0301	07	Pesicka	Marlene M.	$19,241.00
03453117	AB5120	Engineering Tech.	GS	0802	07	Fluery	Solomon G.	$17,723.00
03453117	AB5125	Secretary-Typing	GS	0318	05	Wells	Roberta J.	$13,493.00
03453118	AB5126	Clerk-Typist	GS	0322	04	VACANT		
03453117	AB5129	Environmental Eng.	GS	0819	09	VACANT		

Office of Program Planning & Evaluation

03450008	AB0201	Public Hlth Analyst	GS	0685	13	LaBelle	Roy L.	$35,252.00
03450008	AB0202	Program Analyst	GS	0345	12	Molash	Robert F.	$27,849.00
03450008	AB0205	Statistical Asst.	GS	1531	06	Bohling	Janice .	$14,584.00
03450008	AB0203	Supv. Stat. Asst.	GS	1531	07	Hutcheson	Emma	$17,217.00
03450008	AB4110	Statistical Asst.	GS	1531	05	Ryan	Connie L.	$13,902.00
03450008	AB0207	Periph Equip Oper	GS	0332	04	Mousseau	Diane W.	$11,323.00
03450008	AB0208	Periph Equip Oper	GS	0332	04	Attocknie	Esa	$10,953.00
03450008	AB0206	Statistical Clerk	GS	1531	04	Richter	Joanne L.	$11,328.00
03450008	AB0204	Secretary-Typing	GS	0318	04	Shortbull	Marietta	$12,266.00
03450023	AB4111	Contract Health Clerk	GS	0301	05	Ritzman	Ann H.	$12,266.00

Office of Program Services

03450009	AB9901	Prog. Svcs. Director	GS	0301	14	Bowker	Henry A.	$42,919.00
03450009	AB9903	Secretary-Typing	GS	0318	06	VACANT		
03450009	AB9904	Clerk-Typist	GS	0322	05	VACANT		
03450009	AB4115	Medical Officer	GS	0602	14	Kosa	Anna Maria	$50,491.00

Pharmacy

03450022	AB4101	Chief, Area Pharm. Br.	CC	0660	06	Westley	Theodore A.	$36,962.00

03450022	AB9908	Dep. Chief, Pharm. Br.	CC	0660	05	Pukas	Theodore B.	$32,700.00
Medical Records								
03450017	AB0301	Med. Rec. Librian	GS	0669	12	Ross	Patsy A.	$28,747.00
03450017	AB9905	Med. Rec. Tech. (Typ)	GS	0675	04	Farmer	Rochelle	$12,423.00
Maternal & Child Health								
03450070	AB9902	Medical Ofcr (OB/GYN)	GS	0602	15	Milroy	Thomas W.	$57,912.00
Contract Health								
03450023	AB4404	Chief, CHS Branch	CC	0670	05	Schneiderman	Lary S.	$32,700.00
03450023	AB1202	Contract Specialist	GS	1102	09	Craft	Luetta M.	$22,305.00
03450023	AB4402	Staff Assistant	GS	0301	06	Sexton	Peggy	$16,408.00
03450023	AB4403	General Clerk (Typ)	GS	0301	06	Haaland	Marcia K.	$16,408.00
Dental Health								
03450068	AB5201	Chief, Area Dental Br.	CC	0680	05	Maas	William R.	$37,259.00
03450068	AB5202	Staff Assistant	GS	0301	09	Picotte	Vylla G.	$21,685.00
03450068	AB5203	Secretary (Typ)	GS	0318	05	Schliebe	June L.	$15,129.00
03450068	AB5204	Dental Officer	CC	0682	04	Speath	Leonard	$34,077.00
Health Education								
03450065	AB5401	Public Hlth. Educ.	GS	1725	13	Biehler	Thomas J.	$38,456.00
Nutrition & Dietetics								
03450016	AB0401	Nutr. & Diet. Officer	GS	0601	13	Osborn	Winston C.	$38,456.00
03452725	MI9901	Pub Hlth Nutr (Minot)	GS	0601	12	Becker	Beryl	$33,237.00
Laboratory Services								
03450051	AB4001	Medical Technologist	GS	0644	12	Lambert	Charlotte M	$29,645.00
03450051	AB4002	Secretary (Typing)	GS	0318	05	VACANT		
03450051	AB4114	Medical Officer (Path)	GS	0602	14	VACANT		
Medical Social Services								
03450061	AB0501	Chief, Area SS/MH	CC	0185	06	Varner	Richard L.	$43,919.00
03450061	AB6301	Social Worker	GS	0185	13	Claymore	Betty J.	$36,320.00
03450061	AB6302	Secretary (Typing)	GS	0318	06	Walth	Angeline K.	$17,320.00
Nursing								
03450018	AB0601	Nurse Consultant	GS	0610	14	VACANT		
03450064	AB5301	Consulting PHN	CC	0610	04	Stenvig	Thomas E.	$31,077.00
03450064	AB5302	Staff Assistant	GS	0303	06	VACANT		
03450064	AB5303	Secretary	GS	0318	05	Leppke	Neoma K.	$15,947.00

03453100	AB4201	Nurse Educator	CC	0610	03	Lee	Carolyn B.	$28,572.00
03453100	AB4203	LPN	GS	0621	04	LaRoche	Tracy	$14,248.00
03453100	AB4206	LPN	GS	0621	03	Carreaux	Linda	$12,043.00
03453100	AB4207	LPN	GS	0621	04	Chee	Evelyn	$13,153.00
03453100	AB4208	LPN	GS	0621	04	Fitzpatrick	Clevia R.	$11,693.00
03453100	AB4301	Nursing Assistant	GS	0621	03	Halfred	Cynthia A.	$10,418.00
03453100	AB4303	Nursing Assistant	GS	0621	04	Skjonsberg	Peggy J.	$11,693.00
Optometry								
03566143	OP9901	Health Services Coord.	CC	0662	06	Hamilton	James E.	$51,059.00
03560180	OP9902	Optomretrist	CC	0662	03	Bowyer	Norma Kay	$15,856.00
03560180	OP9903	Health Tech (Opt.)	GS	0699	06	Miles	Monica A.	$14,584.00
Audiology								
03450060	AB6601	Audiologist	GS	0665	13	Oge	Richard A.	$33,116.00
03450060	AB6602	Health Tech. (Aud.)	GS	0699	11	Figenshow	Richard L.	$22,486.00
03450060	AB6603	Secretary	GS	0318	05	White Body	Belva	$13,034.00
Radiological Services								
03450050	AB4205	Diagnostic Rad. Tech.	GS	0647	12	Smith	Curtis	$26,951.00
Office of Tribal Health Programs								
03450082	AB5604	Tribal Affairs Officer	GS	0301	14	Bad Mocassin	Richard T.	$39,133.00
03450082	AB0701	Tribal Proj Spec.	GS	0301	13	Renville	Duane B.	$34,184.00
03450082	AB5603	Tribal Proj Spec.	GS	0301	13	VACANT		
03450082	AB5601	Ind Self Det Proj Ofc	GS	0301	13	Laverdure	Ronald W.	$33,116.00
03450039	AB9907	Tribal Proj Spec-Alc	GS	0301	12	Crawford	Edward J.	$27,849.00
03450069	AB0702	Comm. Health Rep.	GS	0301	12	Leader Charge	Letha A.	$25,951.00
03450001	AB9802	Secretary (Steno)	GS	0318	06	Jackson	Winnifred	$16,854.00
Medical Care & Evaluation & Quality Assurance								
03450062	AB4401	Medical Officer	GS	0602	15	Anderson	Esther E.	$51,972.00
03450062	AB4405	Medical Officer	GS	0602	14	VACANT		
03450062	AB4406	Health Syst. Special.	GS	0671	13	Johnson	Bruce	$37,383.00
Management Trainees								
03453138	AB0107	Admin. Mgmt. Trainee	GS	0301	05	Drappeau	Sharon	$13,084.00
03453138	AB0108	Admin. Mgmt. Trainee	GS	0301	07	Lee	Priscilla	$15,193.00
03453138	AB0109	Admin. Mgmt. Trainee	GS	0301	05	Rowe	Michael	$13,902.00

TOTAL FTP 178

AREA OBJECTIVES

THE MISSION OF THE ABERDEEN AREA INDIAN HEALTH SERVICE IS TO:

> Raise the health status of the Aberdeen Area Native Americans to the highest possible level by ensuring that a comprehensive health service delivery system exists to serve them; and that sufficient options are provided to maximize Aberdeen Area Native American involvement in meeting their health needs.

THE OBJECTIVES OF THE ABERDEEN AREA INDIAN HEALTH SERVICE ARE:

Objective #1 - Accreditation/Certification

A. To attain and maintain accreditation through JCAH or certification through HCFA (Medicare) for IHS hospitals and health center facilities.

B. Completion of plan for expenditure of Medicare/Medicaid collections and application of these monies to the approved Plan of Correction.

Objective #2 - Health Delivery Services

To provide and assure delivery of health care services which meet:

A. The objectives of the Operational Management System; and,

B. Fully utilize Contract Health Service funds.

Objective #3 - Facilities Management, Equipment and Supplies

To effectively and efficiently manage the facilities, equipment and supplies, BEMAR, real property and energy audit programs. To delegate to appropriate Area Office staff the responsibility for Facilities Management and to monitor progress of said program.

Objective #4 - Tribal Management Support

A. To assure that all Tribes and Tribal organizations within the respective Area have access to:

- Orientation and training in the budgeting and planning process utilized by IHS prior to the first stage of the budget cycle.
- Participation with Service Units, Area/Program Offices, and Headquarters in the planning and budgeting process.
- A descriptive analysis of the health services priority system.
- Information demonstrating the relationship of the Tribal/Urban Specific Health Plans to the budget process.

B. Responsible for the presentation of the operating budget to Tribes or Tribal organizations. This presentation will include an explanation of the process utilized by the Area Office/Service Unit to determine the operating budgets.

C. Develop and implement monitoring and information systems that reflect Area support of Tribal development and management of health programs through contracts and grants.

Objective #5 - Financial Management Program

Ensure complete implementation of the Zero Base Budget (ZBB) process to include maximum participation by key operation personnel. Area budget execution process is well conceived, adequately staffed within available resources, lines of communication between program elements and the Financial Management Branch are clearly delineated and routinely observed. All key Area personnel are educated on a continuing basis in the necessity for controlling Indian Health Service obligations in order to observe any fund limitations, e.g., year-end buying or travel ceilings, and to guarantee that operations will remain within resources available.

Conduct annual review of Financial Management operations within the Area.

Objective #6 - Performance Appraisal System

Implements and maintains Personnel Appraisal System (PAS) within the Area.

Objective #7 - Equal Employment Opportunity

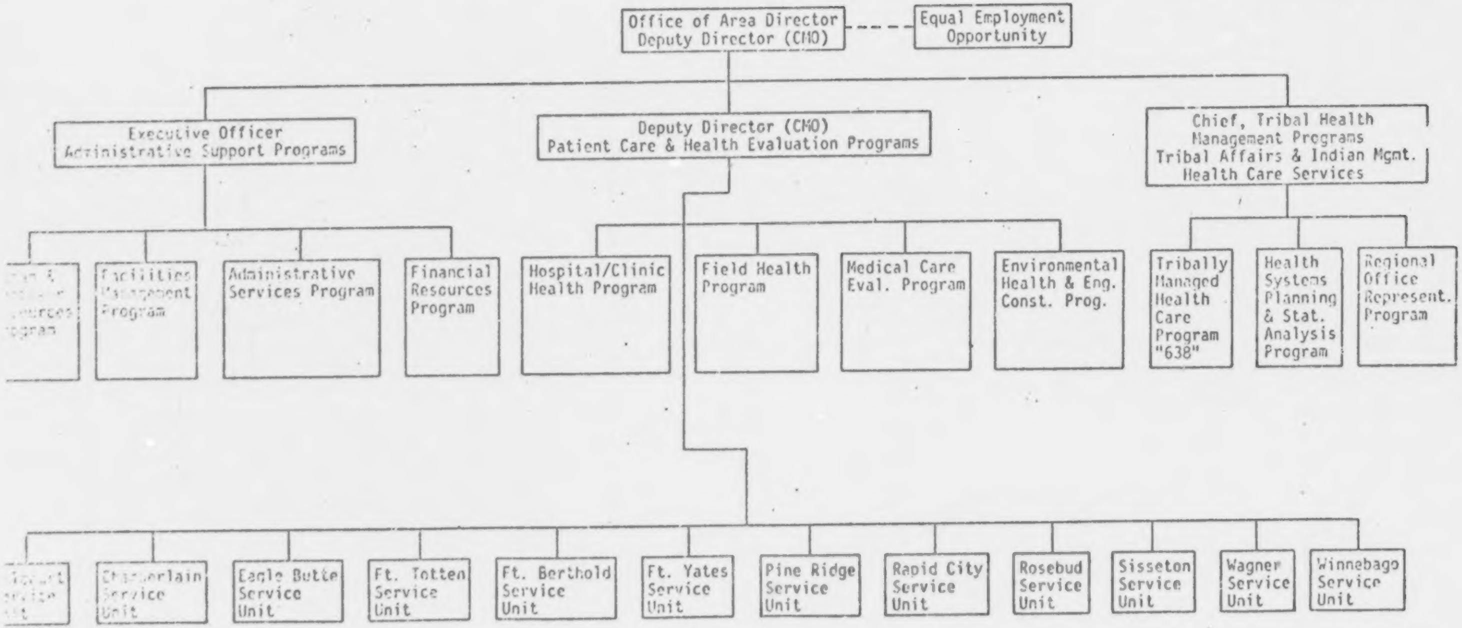
Provide personal leadership and continuing support in establishing, maintaining, and executing a positive health oriented program designed to promote self-determination within the framework of EEO statutes.

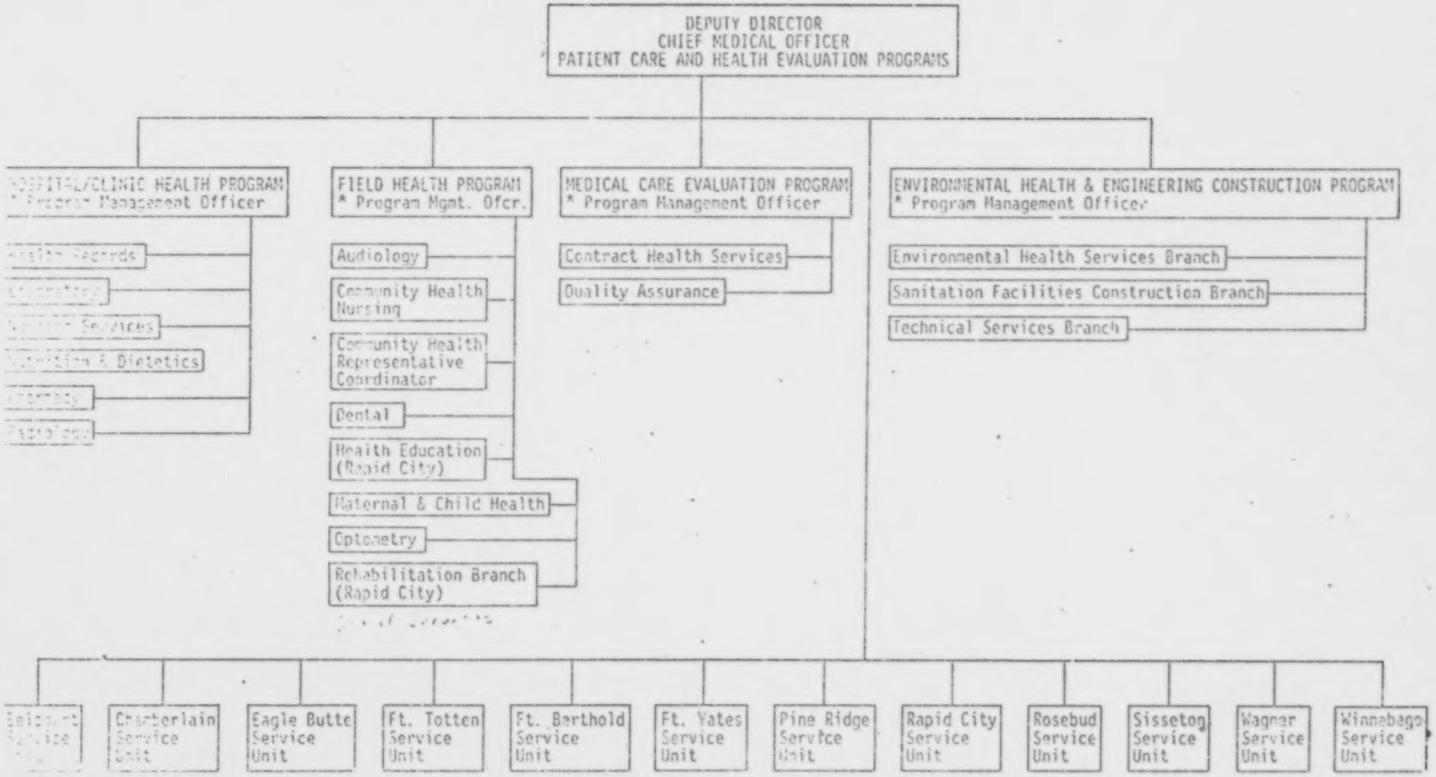
PROPOSED ORGANIZATIONAL CHART

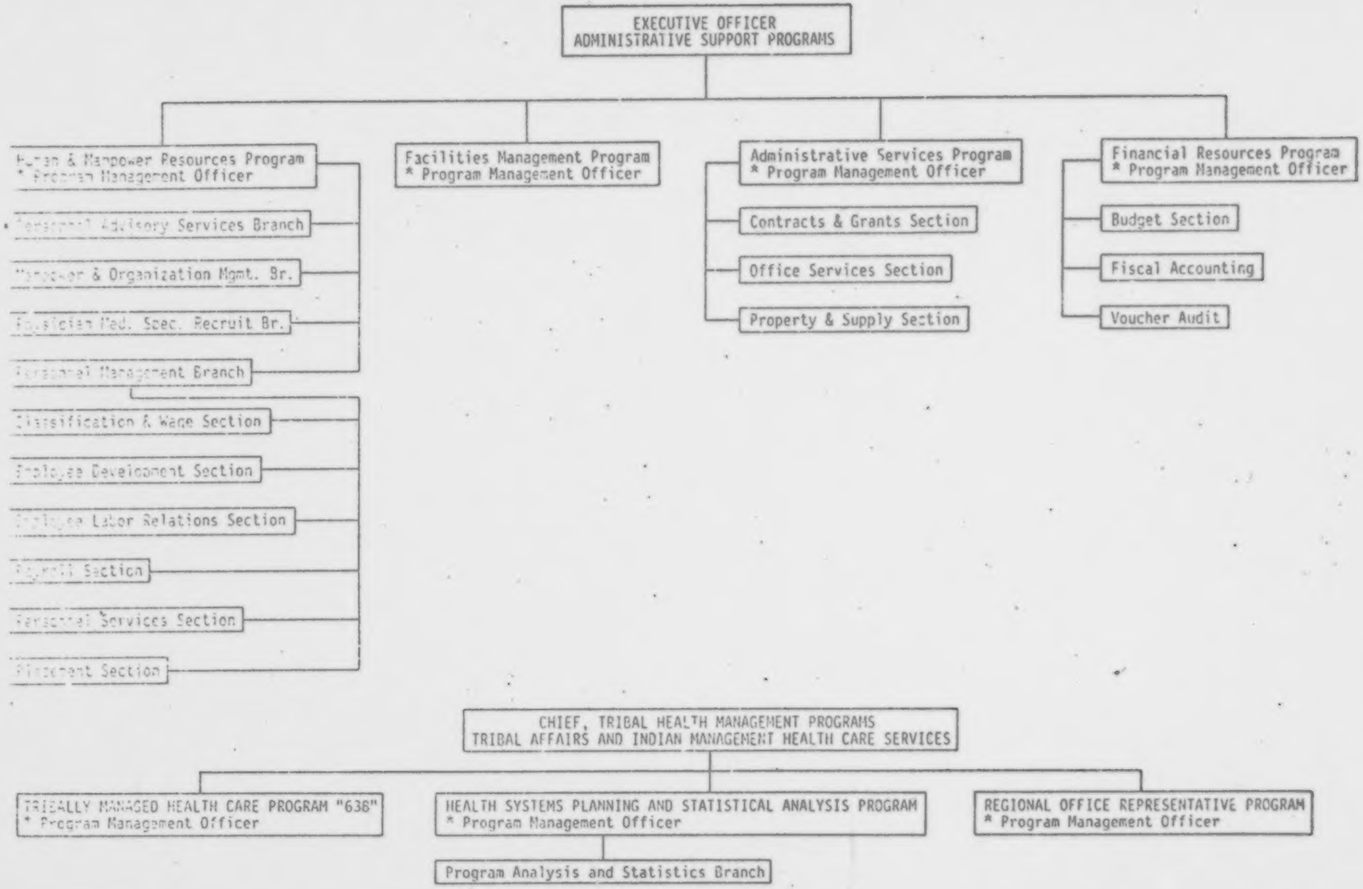
ABERDEEN AREA
CRGANIZATIONAL CHART
April, 1981

APPROVED: Wianne Roberts
Area Director

DATE: 4-24-81.


Office of Area Director
Deputy Director (CMO)
Equal Employment Opportunity
Executive Officer
Administrative Support Programs
Deputy Director (CMO)
Patient Care & Health Evaluation Programs
Chief, Tribal Health Management Programs
Tribal Affairs & Indian Mgmt. Health Care Services
Facilities Management Program
Administrative Services Program
Financial Resources Program
Hospital/Clinic Health Program
Field Health Program
Medical Care Eval. Program
Environmental Health & Eng. Const. Prog.
Tribally Managed Health Care Program "638"
Health Systems Planning & Stat. Analysis Program
Regional Office Represent. Program
Chamberlain Service Unit
Eagle Butte Service Unit
Ft. Totten Service Unit
Ft. Berthold Service Unit
Ft. Yates Service Unit
Pine Ridge Service Unit
Rapid City Service Unit
Rosebud Service Unit
Sisseton Service Unit
Wagner Service Unit
Winnebago Service Unit


DEPUTY DIRECTOR
CHIEF MEDICAL OFFICER
PATIENT CARE AND HEALTH EVALUATION PROGRAMS
HOSPITAL/CLINIC HEALTH PROGRAM
* Program Management Officer
Health Records
Laboratory
Nursing Services
Nutrition & Dietetics
Pharmacy
Radiology
FIELD HEALTH PROGRAM
* Program Mgmt. Ofcr.
Audiology
Community Health Nursing
Community Health Representative Coordinator
Dental
Health Education (Rapid City)
Maternal & Child Health
Optometry
Rehabilitation Branch (Rapid City)
MEDICAL CARE EVALUATION PROGRAM
* Program Management Officer
Contract Health Services
Quality Assurance
ENVIRONMENTAL HEALTH & ENGINEERING CONSTRUCTION PROGRAM
* Program Management Officer
Environmental Health Services Branch
Sanitation Facilities Construction Branch
Technical Services Branch
Belcourt Service Unit
Chamberlain Service Unit
Eagle Butte Service Unit
Ft. Totten Service Unit
Ft. Berthold Service Unit
Ft. Yates Service Unit
Pine Ridge Service Unit
Rapid City Service Unit
Rosebud Service Unit
Sisseton Service Unit
Wagner Service Unit
Winnebago Service Unit


EXECUTIVE OFFICER
ADMINISTRATIVE SUPPORT PROGRAMS
Human & Manpower Resources Program
* Program Management Officer
Personnel Advisory Services Branch
Manpower & Organization Mgmt. Br.
Physician Med. Spec. Recruit Br.
Personnel Management Branch
Classification & Wage Section
Employee Development Section
Employee Labor Relations Section
Payroll Section
Personnel Services Section
Placement Section
Facilities Management Program
* Program Management Officer
Administrative Services Program
* Program Management Officer
Contracts & Grants Section
Office Services Section
Property & Supply Section
Financial Resources Program
* Program Management Officer
Budget Section
Fiscal Accounting
Voucher Audit
CHIEF, TRIBAL HEALTH MANAGEMENT PROGRAMS
TRIBAL AFFAIRS AND INDIAN MANAGEMENT HEALTH CARE SERVICES
TRIBALLY MANAGED HEALTH CARE PROGRAM "638"
* Program Management Officer
HEALTH SYSTEMS PLANNING AND STATISTICAL ANALYSIS PROGRAM
* Program Management Officer
Program Analysis and Statistics Branch
REGIONAL OFFICE REPRESENTATIVE PROGRAM
* Program Management Officer

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Aberdeen Area
Indian Health Service
Federal Building, Room 309
Aberdeen SD 57401

HEW Chrm.
+ Patty [illegible]

December 2, 1981

RECEIVED DEC - 4 1981

Mr. Pat McLaughlin
Tribal Chairman
Standing Rock Sioux Tribe
Fort Yates, North Dakota 58538

Dear Mr. McLaughlin:

Attached is a position paper regarding the Aberdeen Area CHR Program. This document was presented to IHS headquarters staff on Monday, November 23, 1981, by a Tribal Representative.

The FY 1982 proposed budget and anticipated reduction was adjusted in Joint Conference Committee and is presented in the final Bill at $30,000,000. or a reduction of $9,083,000. The FY 1982 budget was $36,295,000 and, therefore, the reduction will be approximately 18%.

Additional information regarding the CHR Program will be forwarded to you.

Sincerely,

for Richard Bad Moccasin
Area Director
Aberdeen Area Indian Health Service

Attachment

ATTACHMENT 4

COMMUNITY HEALTH REPRESENTATIVE PROGRAM REDUCTION

FISCAL YEAR 1982

A Paper Presenting the Justification
for Sustaining the Current Level
in the Aberdeen Area

Presented to the Director, Indian Health Service

From : Indian Representatives
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I. INTRODUCTION:

The Fiscal Year 1982 Indian Health Service budget will result in a reduction in the CHR Program of approximately 18% from FY 1981. The CHR Program has over the past thirteen years become an integral and vital part of the Indian Health Service delivery system. The Indian people now depend on and trust the CHR's as the first and most readily available health provider. This paper strongly requests that the reductions required by these budget cuts be taken from other Areas rather than from Aberdeen. This request is based on facts and conditions that exist in the Area and presented in III. below.

With respect to these cuts, below is a quotation from the House Congressional Record dated November 5, 1981, which gives specific direction to the Indian Health Service managers:

> "The managers agree that the reduction in the Community Health Representatives program should be directed at those Areas which have higher concentrations of health personnel in clinics or hospitals; or programs which have been evaluated and found to be less effective or not in compliance with program regulations. The Indian Health Service is directed to report to the Appropriations Committees the proportions of reduction which represent generalists and the proportion representing specialists."

We wish to further emphasize that this is not just a selfish request and urge that after your review Indian Health Service Management will have cause for such action and not apply the cuts with an across the board percentage.

II. FY 1982 PROPOSED BUDGET AND ANTICIPATED REDUCTION

The proposed CHR budget was $39,083,000. This was adjusted in Joint Conference Committee and is presented in the final Bill at $30,000,000, or a reduction of $9,083,000. The FY 1981 budget was $36,295,000 and, therefore, the reduction will be approximately 18%. This would cause a loss of over 50 CHR jobs, and push the Aberdeen Area even further behind the other Areas.

III. HEALTH AND RELATED PROBLEMS IN THE ABERDEEN AREA COMPARED TO OTHERS.

A. TUBERCULOSIS AND OTHER STATISTICS

Control of tuberculosis and other communicable diseases remains a critical community health need in the Aberdeen Area. Tuberculosis new case rates for the Aberdeen Area are decidedly the highest in all of Indian Health Service and are almost double the Indian Health Service average. Control of tuberculosis remains a significant challenge due to the insiduous nature of the disease, prolonged length of the time required for treatment, and the inability of health care providers to modify treatment protocols to mesh with individual beliefs and customs. The success of efforts to control tuberculosis in the Aberdeen Area are contingent upon consistent followup, monitoring and health education provided to clients between episodic visits to health care providers in the clinic or hospital setting. Involvement of CHR's in this process is seen as critical. As knowledgeable members of the community and under professional guidance, CHR's have demonstrated success and achieved results in assisting with patient compliance and contact investigation on numerous occasions when others have failed. Budget cuts which impact adversely upon CHR staffing in the Aberdeen Area will probably result in an increase in tuberculosis case rates at a time when its prevention and control should be of primary concern.

Further, the IHS morbidity index values for 1981 places the Aberdeen Area at 33%. Infant deaths in 1977 (the latest report available to us) are at 30.2% compared to Oklahoma 13.5%, Tucson 22.9%, USET 21.9%, Alaska 17.6%. At rates per 100,000 population for the fifteen leading causes of death, the Aberdeen Area is the highest with 1,135.6, Oklahoma 683.6, Tucson 837.7, USET 662.7, Alaska 696.5, Navajo 613.8.

B. ECONOMIC, ROADS, TRANSPORTATION, CULTURAL PATTERNS

The Aberdeen Area comprises fifteen separate tribes, three urban centers, and the Trenton-Williston Indian Service Area. The Aberdeen Area covers the states of North and South Dakota, Iowa, and Nebraska.

The Indian Tribes are located on original Reservations set aside by Treaty negotitions and are among the most ecomomically depressed in the nation. There are few natural resources, unlike reservations with minerals, timber, with and other value income resources. Aberdeen Area Tribal resource incomes are very limited.

Consequently, no major industrial development has occurred. The Tribes past economy was based on Federally funded manpower programs. The total unemployment is approximately 70% and will rise as the major impact of cutbacks are felt and seasonal work has ended.

This impact is being felt in the community in the purchasing power of the families. Tribal members do not earn large per annum salaries and are generally on the minimum wage scale. Their purchasing power is used for food and subsistence. Nutrition is an underlying major health problem. Alcoholism, Diabetes, and Obesity are directly affected by nutrition. Hopelessness derived from lack of employment and earning power contributes to the consumption of alcohol. Severe winters and extended number of months in a given year that are "cold" create an energy crisis need. All contribute to desperate economic conditions.

Transportation and Roads are a major contributing factors to access to health care. Most Indian families in the Aberdeen Area do not own the newer compact cars, being forced to purchase the older "gas guzzler" type which fits their incomes. These vehicles (if a family owns one) are non-starters in winter, and many times unable to make a reliable, safe trip to a health destination. Roads on reservations are poor, many are still dirt and/or sparse gravel surfaced.

These factors severely impact the health care delivery system in the Aberdeen Area.

Aberdeen Area Tribes are traditional and isolated from mainstream activities. Their concept of time, work, and savings remains traditional. Their cultural values are deep and impact their daily lives.

They are involved in various types of traditionalism in healing practices. The Indian Health Service's unstable personnel system in health care and misunderstanding of the Native healing practices tend to discredit them. These Tribes' practice Uwepi, Sweat Lodge, and Pipe Ceremonies. Herbalists are active. Suspicion of "white" medicine, which does not provide a holistic approach, remains. CHR's are the interface for the Indian Health Service and the traditional Indians of our Area. Language continues to be a major barrier to health care.

C. GEOGRAPHICAL ISOLATION AND CLIMATE

Rservation areas are scattered, divided, and spread out with the majority of people living in grassroot communities. CHR's have to travel 40 to 260 miles to get patients to health facilities. Roads are constantly in need of repair. There are no commercial buslines, airlines, or railroads serving the reservation. Only 40% of the Indian population households own their own cars. There is presently little or no industry on these reservations.

Climate - Due to cold hard winters and rainy conditions during the Spring, at least seven months of the year poses conditions not conducive to safe transportation. Temperatures vary to extremes in these areas, lows of -46° to highs of 112°.

D. LACK OF MODERN MEDICAL FACILITIES

While other Areas, including Oklahoma, USET, Albuquerque, Alaska, Phoenix, and Bemidji have enjoyed the construction and staffing of new IHS hospitals and health centers, the Aberdeen Area has been left out. Perhaps this is due to better and more effective politics in other Areas.

For whatever reason, antiquated facilities and equipment are a deterent to recruitment and retention of good qualified health professionals. The lack of adequate numbers of health professionals puts an even greater burden on the CHR's. The newest hospital in Aberdeen is Belcourt which was constructed seventeen years ago. Facilities such as those at Rosebud, Pine Ridge, Sisseton, Winnebago, are a disgrace in terms of modern 1982 level health care facilities.

E. REDUCTION IN HEALTH PROFESSIONALS

The Aberdeen Area is considered the "Siberia of the Indian Health Service" and has one-hundred vacancies as of this date, with 32 of those being in nursing and 8 in the medical staffing. The Tribes have been involved in recruitment and retention programs, but with the isolation, severe weather conditions, and antiquated facilities and equipment, it is most difficult to entice health professionals to the Area and keep them. With the current freeze Indian Health Service personnel are accepting positions and transferring to more attractive Areas, i.e., USET, Albuquerque, Oklahoma, Tucson, Phoenix. The Communicable Disease Center has for years past assigned a professional person to the Aberdeen Area. This position was successful in monitoring and managing the Area program for controlling communicable diseases: Tuberculosis, Venereal Disease, Hepatitis, Diphtheria, Measles, Mumps, etc. The position has now been lost to the Aberdeen Area due to a cutback. The loss again places a heavier load on the Public Health Nurses and the CHR's. Preventive health is the truly effective health measure. "An ounce of prevention is worth a pound of cure."

F. REDUCTIONS IN THE ENVIRONMENTAL HEALTH , HEALTH EDUCATION, AND AMBULANCE BUDGETS

The impact of the budget cuts in Health Education, Environmental Health, and the EMS Programs besides the other community services programs not funded through Indian Health Service will force the CHR's to fill the void and place a heavier workload on them with less manpower. CHR's on many reservations are now carrying out the full responsibilities for safe water, including fluoridation and chlorination. They also are driving ambulances and functioning as the local health education specialist.

SUMMARY

The overall health status of Indian people has been improved and most notably started rising with the implementation of the Community Health Representative Program. CHR's have grown from inexperienced fledglings and have overcome the skepticism that goes with change, and now provide the nucleus of health workers who are responsive to all the health needs of Indian people. Indian Health Service is dependent upon the services CHR's provide.

The Aberdeen Area CHR's have provided leadership for the entire Indian Nation. We hope Indian Health Service will meet the challenge we place before you and take into consideration the grave need we have in comparison to the other Areas.

Senator **Melcher**. Our next panel is Larry Cournoyer, chairman, Yankton Sioux Tribe, and Agnes Gullikson, the treasurer of the tribe; Robert Chasing Hawk, chairman of the Cheyenne River Sioux Tribe, Eagle Butte, S. Dak.; Rollin V. Ryan, chairman, Sisseton-Wahpeton Sioux Tribe, Sisseton, S. Dak. I believe you are first, Larry.

STATEMENT OF LARRY COURNOYER, CHAIRMAN, YANKTON SIOUX TRIBE, WAGNER, S. DAK.

Mr. **Cournoyer**. Thank you, Senator, for the opportunity for the Yankton Sioux Tribe to submit testimony. I will make my comments rather general and brief.

The Yankton Sioux Tribe would like to recommend, for one thing, that the Indian Health Service maintain construction moneys. The Yankton Sioux Tribes have been in need of a new facility for some time, and we are on the top 10 list that has been put out by the Indian Health Service for new construction, and we would like to see that money maintained. It does a lot for our area. I think it does a lot for the morale of our people if they have a decent facility to go to for health services. The CHR program has been cut back some 18 percent down there.

Even though it is not direct health care related, on a reservation where you have an unemployment rate that runs in the 80- to 90-percent range, it is awfully difficult for our people to live with the inflationary costs and the high costs of fuel and still be able to get to the hospital. Our hospital is located, for most of our communities, other than the Wagner area, at least 25 miles away, and a round trip of 50 miles, and the availabilty of vehicles and the cost of fuel, makes it impossible for some of our people to be able to provide themselves with transportation. Therefore, we hope you keep money for the CHR's in the budget.

Alcoholism. I do not know what the status is of all the programs, but I have heard that those people that are presently under NIAAA funding are going to have a difficult time getting alcoholism funds in the Indian Health Service budget. I recommend that one of the priorities of Indian Health Service should be to keep alcoholism as a line item in the budgets. It is, in my opinion, as well as many others, the No. 1 cause of many of the medical or health problems that we do have.

On our reservation the Indian Health Service director—I do not know if this is a fact or not—but he told me before I left that he was directed to begin scrutinizing his budget and see if there is any way he could cut back some 20 percent in there. We have at our Indian Health Service hospital a very limited amount of Contract Health Care funds. A lot of the attention that is provided to our people is provided right there at the local service unit, and they are oftentimes deficient in the number of employees that they have on board. I think that provides less health care and less care for our people. I have seen where they needed Contract Health Care. They have not been able to get it. Right now, I believe we are running $25,000 in the red in Contract Health Care from the early amounts that we were supposed to spend in the first quarter. And this. I think, is causing problems in getting the proper health care to our people, because the people at the Indian Health Service are afraid to provide the Contract Health Care to the patients that really need it. They claim that their jobs are jeopardized by doing so, and I think that a poor method of insuring that they stay within their budgets is to deny people that need Contract Health Care that care.

Finally, we also have hopes if there are to be any cuts, they come at the administrative level, central office, area office. I think those cuts should be made there, rather than at the service level. I guess primarily that is the testimony that I have got to present.

Senator MELCHER. Thank you both, very much.

Robert Chasing Hawk.

STATEMENT OF ROBERT CHASING HAWK, CHAIRMAN, CHEYENNE RIVER SIOUX TRIBE, EAGLE BUTTE, S. DAK.

Mr. CHASING HAWK. Thank you, Senator Melcher. On behalf of the Cheyenne Sioux Tribe, I would like to thank the committee for giving us this opportunity to express the health concerns that we have on my reservation.

First of all, prior to the budget cuts, we the Cheyenne Sioux Tribe of the Indian Health Service, struggled to improve our health care to our Indian people. This budget cut of fiscal year 1982 has dealt a devastating blow to our cause. We will fall far short on meeting our goals in providing good health care to our Indian people.

My tribe is one of the most economically depressed nations around the country. Since the budget cut, the unemployment rate went to an all-time high of 68 percent.

This contributes to alcoholism problems, drug abuse, and psychological effects on the Indian people.

The Bureau of Indian Affairs is responsible for the construction and maintenance of the road system on the reservation. On our reservation there are approximately 251 miles of roads: 156 miles of road are in poor condition—needs part gravel; 46 miles of hard surface roads; and 49 miles of good gravel roads. Just imagine, Mr. Chairman in case of inclement weather, such as rain, it is hard to travel, and our economically depressed Nation, the people on my reservation, cannot afford to purchase a vehicle.

The Eagle Butte Indian Health Service has always been underfunded, which creates a lack of modern equipment; inadequate materials and supplies; and low salaries to attract doctors. Also, the isolation of the service unit.

At the present time we have two temporary doctors with a patient population or service population of 4,800 Indian people on my reservation. That is a ratio of one doctor to 2,400 patients, or service population.

Right now we need doctors who will be there during the night. Also, we really need other Indian programs to provide a good health care delivery service on our reservation.

Senator MELCHER. Do these 4,800 people actually reside on the reservation?

Mr. CHASING HAWK. Yes. We got the document from the area office.

Senator **Melcher**. There are only two doctors for the 4,800?

Mr. **Chasing Hawk**. Right. There are two doctors on a temporary basis now; two doctors who are permanent are on leave.

Senator **Melcher**. There are two doctors there right now?

Mr. **Chasing Hawk**. Right, and two permanent doctors who are on leave now, Christmas leave, I guess.

Senator **Melcher**. Well, will they come back?

Mr. **Chasing Hawk**. They will come back in about 2 weeks.

Senator **Melcher**. Then you will have four?

Mr. **Chasing Hawk**. We will have four again. But, these two temporary doctors will leave whenever their assignment duty is up.

Senator **Melcher**. How long is that?

Mr. **Chasing Hawk**. Between 2 to 4 weeks, if I am correct.

Senator **Melcher**. Then you will be back to two doctors.

Mr. **Chasing Hawk**. Right.

Senator **Melcher**. How big is this reservation?

Mr. **Chasing Hawk**. The reservation is approximately 2 million acres of trust land, BIA allotted land. We have a total tribal membership of 8,600. There are 4,800 living on the reservation, plus other tribal nonmembers who are residing within our reservation.

Senator **Melcher**. How many schools do you have on the reservation?

Mr. **Chasing Hawk**. We have Eagle Butte School, which is a boarding school. We have four outlying BIA schools. We have one 638 contract school. We have four clinics out in the communities; two in the east end and two in the west end. And, this CHR program is a vital part of the health care delivery system on the reservation because of lack of transportation from some of the communities. One community is about 86 miles away. There is a group of 15 householders in that community and only five cars. It takes $25 to $30 to transport a patient over there. Maybe the administrative costs should be reduced. In other words, what President Reagan is saying is that he is going to trim the bureaucracy of the Federal Government. There is a bureaucracy within a bureaucracy at the Bureau of Indian Affairs and Indian Health Service that needs to be trimmed; then channel all the funds to the grassroot Indian people.

Senator **Melcher**. You have one hospital?

Mr. **Chasing Hawk**. There is one hospital.

Senator **Melcher**. There is no outpatient clinic?

Mr. **Chasing Hawk**. There are four outpatient clinics.

Senator **Melcher**. How often does the doctor get to these clinics?

Mr. **Chasing Hawk**. Once a week.

That leaves one doctor to be stationed in Eagle Butte and one doctor to go out when the other two doctors are on leave.

Senator **Melcher**. Have there been any complaints about the functioning of the hospital?

Mr. **Chasing Hawk**. Sure; there have been a lot of complaints.

Senator **Melcher**. What are the complaints?

Mr. **Chasing Hawk**. Since the existence of the Indian Health Service.

Senator **Melcher**. Basically, what are the complaints?

Mr. **Chasing Hawk**. Basically, it is underfunded.

Senator **Melcher**. Any malpractice?

Mr. Chasing Hawk. Not malpractice. OK, there is some malpractice. There is a loss of confidence in these doctors because, like I said, when there are low salaries, isolation, you do not get good doctors to come to the area. Field doctors come to my office and want to come to Eagle Butte, but when they come to Eagle Butte—no way.

Senator Melcher. The hospital is at Eagle Butte?

Mr. Chasing Hawk. Right.

Senator Melcher. How big is Eagle Butte?

Mr. Chasing Hawk. Eagle Butte is a population of around 2,400 and that includes non-Indians. It is a non-Indian community to begin with, but the Cheyenne River was moved from the eastern part of the reservation when the dam was built back in the sixties.

Senator Melcher. Eagle Butte; how far is that from Belle Fourche?

Mr. Chasing Hawk. That is 150 to 180 miles.

Senator Melcher. If you, for some reason, were not able to get hospital care at Eagle Butte, where is the closest hospital?

Mr. Chasing Hawk. The closest hospital would be Mobridge, Gettysburg, or Pierre. I think we contract with the Mobridge hospital.

Senator Melcher. Mobridge is over 100 miles, is it not?

Mr. Chasing Hawk. It is approximately 85 miles north of Eagle Butte.

Contract health funds are depleted, and I think we contract with Rapid City hospitals, and there are a lot of Indian people who need to go to a better doctor, but because of limited funds and contract funds, they cannot make any referrals.

Senator Melcher. You are truly isolated.

Mr. Chasing Hawk. Right. On top of this, the unemployment rate is sky high and the people cannot purchase health insurance, which is badly needed on any reservation.

Senator Melcher. Do any of the tribal employees have health insurance?

Mr. Chasing Hawk. Very few have health insurance.

Senator Melcher. It is very hard to get then, for anybody?

Mr. Chasing Hawk. I think my health coordinator over here—no, we do not have this as a package.

Senator Melcher. You do not have any. I have a sister-in-law who is from Eagle Butte, a member of the tribe. She is one of those 3,600 who lives off the reservation in Los Angeles.

Mr. Chasing Hawk. Another thing, Senator Melcher, a couple of years ago we built an outpatient clinic. At that time we were funded to hire some doctors and dentists. A California tribe filed a lawsuit that took the money away from us. So we used our IHS moneys to fund that outpatient clinic. I think another law was passed, or the regulations were changed, so that non-Indians, married to a member of the tribe, would be able to use the services of IHS. The money was not increased.

Senator Melcher. The eligibility increased?

Mr. Chasing Hawk. Right, but the money stayed the same. You know, there are attorneys and doctors making high salaries who are using our Indian Health Service moneys. They could have their own health insurance.

Senator **Melcher**. That is a good point.

Mr. **Chasing Hawk**. That is all I have, Senator Melcher.

I will submit written testimony.[1] We have one, but we have to do some revision. So, within 30 days, we will submit written testimony, plus a demographic study which has been done on my reservation. It should be completed within 15 days.

Senator **Melcher**. We will make that part of the record at this point. Just to advise all participants and all members of the tribes involved in these two areas, any written testimony received up to 30 days will be made part of this record.

Rollin Ryan.

STATEMENT OF ROLLIN V. RYAN, CHAIRMAN, SISSETON-WAHPETON SIOUX TRIBE, SISSETON, S. DAK.

Mr. **Ryan**. Thank you, Senator, for allowing me to testify here today.

I think on our reservation the problem we have, also, is with contract health service. A lot of people are being turned away from the hospital because they are not considered in life-threatening situations, but I can see a lot of our older people come in this category. I think if there were more preventive health on the reservation—my mother died from cancer, and they told me down at the Minnesota University Hospital in Minneapolis that she was carrying this cancer for 6 months. I do not know how many times she had been into CHS for physicals, but they never detected that. The doctor told me if they would have detected that, at that time, they probably could have saved her. But she was not considered one of those life-or-death situations.

So I do not know how many thousands of dollars they spent on her down there, and yet she still died. I think that happens a lot with our older people. They are the ones who are affected by it most.

I think part of the problem in the budget is the inflation. I do not think the cost of inflation is included in there. So, we are going to wind up the same way again this year in the contract health service.

I would like the committee to consider that.

Another program on the reservation that is very important to me is the alcoholism program. We are taking a lot of steps in trying to control alcoholism. We took a survey—I think it was in 1976. At that time I was working on the alcohol program as a counselor, and the alcoholism rate on the reservation at that time was at 51 percent. When it is that high, it is considered epidemic stage. Now we are here, 5 years later, so I imagine it is getting a lot higher because we are dealing with two generations now.

What I see the alcohol program doing now is dealing with the physical part of the illness. What we need on the reservation, as I see it, is a mental health clinic to deal with the psychological part of the illness. Then, we may get the thing under control. I know we are never going to completely wipe it out, but we must get it under control. A lot of our health dollars are spent on alcohol-related problems.

Our CHR program: I think that is very vital on our reservation. They are also dealing with a lot of older people and handicapped people; people who are not able to get to the health service unit because of a lack of transportation. A lot of those handicapped people need help to get around.

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[1] Not received at time of printing.

So, if there are going to be any cuts, I do not think it should be in the direct services to the people. I think it should come from the top. I think some of the moneys that are cut should be directed to programs on the reservation, to improve the programs that they do have. I see a lot of our programs are not adequately funded, and I see a lot of problem areas. We just do not have the money to deal with those problems. We have problems every day that come up that we are not able to deal with because of regulations. The regulations say we cannot do this. So that gets me to the point of direct funding to Indian tribes. Let us set those priorities and try to solve our own problems.

I have some written testimony for the record. Thank you, Senator.

Senator MELCHER. Thank you very much. Thanks to all of you on this panel.

Your prepared statement will be made a part of the record at this point.

[The prepared statement follows:]

PREPARED STATEMENT OF ROLLIN V. RYAN, TRIBAL CHAIRMAN, SISSETON-WAHPETON SIOUX TRIBE OF NORTHEASTERN SOUTH DAKOTA, SISSETON, S. DAK.

The provision of medical and health services have been provided to the Sisseton-Wahpeton Sioux since 1867, and always has been understood to be an inherent part of the contractual trust responsibility of the United States to the Tribe, as stipulated in the Tribe's Treaty of February 19, 1867. Medical services were first provided by Army Surgeons, then by Commissioned Bureau of Indian Affairs doctors, until two decades ago when the federal clinic and hospital was turned over to the Public Health Service, and as much without Tribal consultation.

Medical services for Indians in northeast South Dakota preceded the establishment of any hospital in the reservation area for the Sisseton-Wahpeton Sioux Tribe. While the present Indian Health Service hospital and clinic is antiquated, locally, Indian people still consider it to be their own facility and a part of the continuing trust responsibility owed them by the United States.

Beginning in 1970, the Sisseton-Wahpeton Sioux Tribe began contracting for preventative and other health related IHS programs such as the C.H.R. and Family Planning programs. Tribal members reached out for and earned specialized training so as to be providers of contracted health services for their people. Their influence has been felt as can be evidenced in reduced instances of disease, such as T.B. and infant mortality reduction. The Tribe has had ten (10) years of experience in administering health programs, and has successfully met challenges and reaped the rewards of seeing the results of healthy children and people.

The current Reagan Administration's proposal to reduce the federal budget is an admirable effort; however, when arbitrarily leveled at Indian health programs, the effect is one of fratricide, or an earlier federal policy version of killing off Indian people by denying them essential medical and health services.

The Sisseton-Wahpeton Sioux Tribe has no quarrel with the intent of the Administration to reduce federal bureaucracy at the Indian Health Service's Central and Area offices. A few years ago, the Congress' American Indian Policy Review Commission revealed that over 65 percent of the federally appropriated dollars for Indian services and programs never reached this reservation, it stayed and was consumed by the administering federal agency. These funds could build a new clinic and a new 15-bed inpatient hospital for the Sisseton-Wahpeton Sioux Tribe and staff it with doctors and other medical personnel.

The Sisseton-Wahpeton Sioux Tribe took very seriously the Indian Self-Determination Act, Public Law 93-638. Even before passage of this law, our Tribe encouraged and supported through donations of nickels and dimes, our young people's desire to be doctors and nurses. Last Spring, a member of our Tribe graduated from medical school and is interning in preparation for his return home to practice medicine at home. Another young man is nearing completion of medical school. Others are in nursing school to become R.N.'s, Lab Technicians, Radiologists, L.P.N.'s, and Hospital Administrators. The proposed federal budget cuts shall mean that our young people have no place to apply their skills at home. Our hopes for them and ourselves shall have been broken and shattered.

We urge the Congress to consider the impact of unwise decision-making with regard to budget reductions. If trimming must be done, do it at the top, but keep the grassroots intact, and expand it so that it can grow. The health of an Indian Nation is at stake.

Senator **Melcher**. The next panel is Sonny Waln from the Rosebud Sioux Tribe; Matt Pilcher, from the Winnebago Tribe; and Reva Walker, nurse consultant, from the Three Affiliated Tribes of Fort Berthold Reservation.

Matt Pilcher, you are up next.

STATEMENT OF MATT PILCHER, TREASURER, WINNEBAGO TRIBE OF NEBRASKA, WINNEBAGO, NEBR.

Mr. **Pilcher**. Thank you, Senator, for offering the Winnebago Tribe from Nebraska this opportunity. I am going to summarize a lot of these things that are in my written testimony.

Presently, due to budgetary cuts from both the Bureau of Indian Affairs and the Indian Health Service, the Winnebago Tribe now has the privilege of saying that 74 percent of our people are now unemployed on the Winnebago Reservation. Of the 26 percent who are employed, 10 percent are employed part time and 16 percent full time.

Another concern of ours, we presently have four vacant nursing positions at the Indian Health Services unit, which means inadequate nursing care. This forces the service unit to refer patients to contract area hopitals in Sioux City, Iowa.

We would like to ask at this time for a waiver from the Indian Health Service for the service unit to hire direct for these nursing vacancies. The present system in effect is totally inadequate. The nurses who apply for positions have to go through a lengthy process through the regional office in Kansas City.

We have one nurse who had applied in May of 1981. Somehow or other they lost her records, so she had to start from scratch again.

For 6½ years the Winnebago Service unit has been operating a DDU unit, which deals with alcoholism and drug abuse. This is on a very minimal budget, and of those 1,373, 250 were members of the Winnebago Tribe. Many of these were repeaters. I would like to say, Senator, that of the remaining 1,123, 90 of these were members of the Crow and Northern Cheyenne Tribes of Montana.

We have also served different tribes from out of the area, from as far away as Washington. Many of these people, after they get out of the DDU's, stay in our community, which places an added strain on our already depleted budget for health and social services.

We now have a dental program that has served 1,544 patients in the last year. Any budget cuts will further threaten those. We have an EMS program. We made a total of 290 calls in the past year. Many of these were life-threatening; people who had strokes, accidents, fires. I know of a couple instances where children were involved.

I know this is not part of the health budget, but we have a food distribution program which operates out of a Winnebago Tribal facility. As of now we have served a total of 1,200 individuals. These are people from the Omaha Reservation, the Santee Sioux Reservation and the Winnebago Reservation. Of that total, 140 are non-Indian who are eligible for surplus food.

It is our recommendation that cuts should be absorbed at area offices and at the Indian Health Service office in Rockville, and leave intact all 633 programs. We are concerned about the cuts in health representatives and any other field health programs that might be operating on the reservation.

We are further concerned with the President's signing last week of the Federal Employment Act. We are concerned where the funds are going to come from to pay those salary increases.

Just as an instance, I would like to ask some people in this room to stand up. It just occurred to me after I was sitting in here, we have Eleanor Robertson, director of the Aberdeen area office. We have Ellen Ellery, deputy director over there. We have Dr. Rupert Clank here from the Aberdeen area office. We have Mr. Ron Lavinger from the Aberdeen area office, and Richard Bad Moccasin and Bill Wossom. I will bet you those people there have salaries which total well over $200,000. These are the kind of things that we are concerned about when we are faced with the cuts.

Were you ever in the service, Senator? This is like saying we have to cut the budget of defense, so we are going to cut out buying bullets for those infantrymen during the war. In effect, that is what is happening, with all these forced budget cuts coming down, and they always come down to us on the reservation. This is the CHR, our public health nurses, anything else, we are down there dealing with the illnesses of Indian people.

Now, with all these people here, before $1 can buy one pill for a sick Indian person, it has to go through all these people. That is the kind of thing we are faced with down there.

Even my travel here: I am a tribal councilman. I am the treasurer of our tribal council, and I put a real tight squeeze on that, and maybe what I am saying here is threatening my ride back to Aberdeen because I bummed a ride with the people I am talking about, but——

Senator MELCHER. Welcome to Billings.

Mr. PILCHER. I might put a strain on one of the local tribes here, but we are really slightly concerned with those, Senator. I would like to say I have heard, over and over here, different people saying one of our main problems is the problem of alcoholism among our people. It is becoming intensified now with unemployment and the uncertainty of the future of many of our people's jobs. We are running into more and more of these problems. We are facing cuts in our mental health program. I was a victim of one of those cuts. I was working in the mental health program, so I am now out of work. So, we can dig up some money for those kind of things.

I want to thank you for this opportunity. That is about all I have to say right now.

Senator MELCHER. The 1,373 admissions to the 30-day treatment of the drug dependency unit at the Winnebago Hospital, was most of that alcoholism?

Mr. **Pilcher**. Yes. In the past few years we are seeing more and more drug abuse coming in.

Senator **Melcher**. Along with it, with the younger people generally?

Mr. **Pilcher**. The older ones are alcohol and the younger are both alcohol and drugs.

Senator **Melcher**. Mixed?

Mr. **Pilcher**. Mixed.

Senator **Melcher**. Thank you, Matt.

The material you submitted will be made a part of the record at this point.

[The material follows:]

COUNCIL OFFICERS

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Winnebago Tribal Council
P.O. Box 687
Winnebago, Nebraska 68071

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Karl Baker
Dorothy Holstein
Alvin Keisey
David L. Snow
Neola E. Walker

402 - 878-2272

December 18, 1981

There are five basic decisions now being implemented by the Indian Health Service at the Washington and Aberdeen Offices which will have a devastating impact on the delivery of health services to the Winnebago people during F.Y. 1982.

The decisions are in order of their greatest negative impact, as we at Winnebago deem them - 1) The apparent decision that I.H.S. and B.I.A. programs are not part of the vital entitlement programs that the Reagan administration is protecting. Why are I.H.S. and B.I.A. programs not viewed as entitlement programs by the Office of Management and Budget? It certainly seems to be reasonable to maintain that programs based upon Treaty and Trust Responsibilities should receive even greater protection than programs such as Social Security based upon legislative enactments.

2) I.H.S. at the Washington level apparently and at the Aberdeen Area by memo dated 11/17/81 (attached) have initiated a 10% across the board cut in all Service Unit programs. The loss of $170,000 in services and jobs to the Winnebago community will be nothing short of catastrophic. All of the information we are aware of indicates that Congress has approved increases of up to 8% in the I.H.S.

hospitals and clinics accounts for F.Y. 82. On whose authority is the intent of Congress overridden? Does the Indian Health Service have the authority to shift monies appropriated by Congress out of direct services and into other line items? Why must the Service Units suffer at the expense of overpaid and incompetent Area and Headquarters personnel? It is a commonly known scandal within I.H.S. that now that travel monies are frozen, the Area Office consultants and other highly paid staff do absolutely nothing.

3) The attack upon the C.H.R. Program constitutes an insidious effort to decrease, on a national basis, almost 20% of the positions in the C.H.R. Program. As a result the program within the Indian Health Service which employs the greatest number of Indian people will be cut by almost a fifth (1/5). Such an effort, if allowed to be implemented, will result in the single most sweeping instance of government sanctioned racism in our lifetime. The Community Health Representative Program has been drastically cut and will only have a negative impact on all of Indian Country, this is the one program all Tribes have in common, and is considered the HEART of our Health Care Delivery Systems. Cut the HEART out and our entire health system will die. CHR's are functioning as Home Health Aides, Sanitarian Assistants, Dental Assistants, interpreters of health care and how and when to take medications, Optometrists Aides, they monitor and follow TB patients, assist in speical clinics, i.e. immunizations, diabetes screening, hearing screening, lead poisoning screening, etc. etc. Since our Tribe contracted under the authority of P.L. 93-638 in May 1979, to provide a Field Health Program, we have managed to raise our immunization level for infants and children, 0 - 5 years of age, from an unacceptable 49% to 100% for two quarters within last FY 81. We are now holding at 98%. We also manage the audiology program, environmental health program, health education, mental health, and community health nursing programs under this contract, and have been able to change them to be more responsive to our needs. We are now

actually practicing preventive medicine.

4) The outline of the still tentative I.H.S. budget is attached. No appropriating body has directed that a single dollar be spent to raise the pay of a single I.H.S. employee. As a result, the money earmarked for services to Indian people will be absorbed at the rate of 15 million dollars to increase I.H.S. salaries. This should not be allowed to happen since it will negate the expressed will of the Congress of the United States to at least maintain or increase the level of direct health services to the Indian people. Why is it not possible to absorb the entire pay act increase by cutting back either all or part of the twelve Area offices in the I.H.S.? All other governmental agencies are experiencing significant middle management Reductions in Force - why not institute such reductions in all the non-direct services components of I.H.S.? The bottom line should be if you are not directly involved in patient care go elsewhere for employment.

5) There will be a decision made by the I.H.S. and its new Director, Dr. Everett Rhodes, concerning the future contracting of health services to Indian tribes under the existing P.L. 93-638 process. Here at Winnebago the Tribal Health Program is positive proof that a higher quality and more efficient delivery of health services are the direct result of Tribal contracts. To cite just one example: The Mental Health Program under the 638 Contract has responded directly to a Tribal priority to work more closely with the seniors of the Tribe. As a result mental health needs of the seniors are being met and a trusting relationship has developed to the point that when an elderly person of the Winnebago Tribe requires Nursing Home care the acceptance of this care is no longer viewed as the traumatic resignation of the individual but rather as an opportunity to

spend the later years of their life with friends. In each component of the Health Department similiar illustrations are manifested on a daily basis.

Three special notes:

1) I.H.S. needs to provide direct hire authority to its Service Units to overcome the difficulties imposed by Federal hiring freezes.

2) I.H.S. may be cutting funding for the Special Diabetes Projects and this would result in the loss of a very signigicant program since the Service Units could not possibly fund it.

3) The Winnebago Hospital Drug Dependency Unit still lacks any substantive assistance from the Indian Health Service despite the fact that after 6½ years of existence, 1,373 admissions into the 30-day Treatment Programs have occurred and 90 of those admissions were individuals from either the Northern Cheyenne or Crow Tribes of Montana.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Winnebago

Memorandun

Copy to all Supervisors

Date November 17, 1981

From AO-EO

Subject FY 1982 Budget

To

Service Unit Director, All Facilities
Program Managers - Dental
Health Education
Community Health Nursing
Mental Health
Tribal Contractors

In order to respond to a directive from Indian Health Service Headquarters, you are to advise the Area Director's Office by the Close of Business on November 30, 1981, what you would cut from your budget or location to comply with a 10% reduction in resources.

Please be sure to discuss Service Unit reductions with Tribal administration.

Be specific as to services and costs that would be reduced.

Thank you.

Alan J. Allery
Executive Officer
Aberdeen Area I.H.S.

NOV 23 1981
WINNEBAGO, NEBRASKA

Indian Health Service Budget
(In Millions)

tegory	FY 1981	Carter's Proposed Budget	Reagan's Proposed Budget	House Budget	Senate Appropriations Committee
inical Services					
Hospital & health clinics	302.568	245.42	318.146	325.146	325.146
Dental health	16.563	18.811	18.129	18.629	18.629
Mental health ✓	7.080	6.0	6.0	7.8	6.0
Alcoholism	15.237	17.387	16.969	16.969	16.969
Maintenance & repair ✓	8.611	9.413	8.611	8.611	8.611
Contract care	107.465	118.129	115.028	115.028	115.028
ub-total Clinical Services	457.524	515.16	482.883	492.183	490.383
reventive Health					
Sanitation ✓	14.340	15.685	14.177	14.177	14.677
Public health nursing	7.592	8.301	8.301	8.301	8.301
Health education ✓	2.009	2.285	2.285	2.285	2.285
Community Health Representative	36.295	39.775	39.083	39.083	34.583
b-total Preventive Health	60.263	66.046	63.846	64.346	59.846
ther					
Urban projects	8.900	8.900	4.450	9.790	0
Health manpower	5.688	7.317	3.792	7.317	3.992
Tribal management	3.029	3.029	2.744	2.744	2.744
Program management	50.886	54.440	53.050	52.050	52.050
Equity fund	7.856	16.054	16.054	16.052	14.054
1981 Pay Supplemental	12.556	12.556	0	0	0
ub-total Indian Health Service	606.675	654.892	625.819	629.484	623.069
ndian Health Facilities					
New & replacement hospitals	25.693	37.4	7.9	7.9	9.928
Hospital modernization & repair	3.3	0.2	0.2	0.2	0.2
Outpatient care facilities	4.456	6.307	0	10.014	10.014
Sanitation facilities	50.240	73.0	0	28.625	26.125
Personnel quarters	0.780	0	0	0	0.35
ub-total IHS Facilities	84.469	116.907	8.1	46.739	46.617
OTAL IHS BUDGET	691.144	771.799	634.919	676.223	669.686

Senator MELCHER. Next is Reva Walker.

STATEMENT OF REVA WALKER, NURSE CONSULTANT, THREE AFFILIATED TRIBES OF THE FORT BERTHOLD RESERVATION, NEWTOWN, N. DAK.

Ms. WALKER. Thank you. First I would just like to talk about Fort Berthold and the reservation area and the population and employment rates. Then I will review the services which the tribe offers and the services the Indian Health Service offers and then make some recommendations for budget cuts.

We have a population of about 3,200, according to BIA's population report released in June. We have an unemployment rate of 63 percent, and of our work force, 44 percent earn less than $5,000 annually. Prior to the budget cuts, the tribe, overall, employed about 220 people. We now have about 150 employees with that number decreasing daily.

The tribe has a health insurance policy for its employees.

Prior to the 1950's, the Mandan Hesa and Rickerock Tribes had a hospital on Fort Berthold and that was one of the major losses that occurred with the Airosee dam. Since that time, we have had contract care and that contract care has been a different situation for tribal members. Distances to health services are great; the closest hospital facility is 35 miles and usually 120 miles to the Minot Air Force Base.

Contract care funds have been inadequate. However, there have been cost-of-living increases, and I would like to list those.

In 1979, Fort Berthold: 23 percent increase. That was $876,206.

In 1980 there was a 21-percent cost-of-living increase for contract services, and that was $917,909.

Interestingly enough, in 1981, when cost of living was soaring and every cost in hospital care was increasing, there was a 2.3-percent increase, $209,300.

The Indian Health Service service unit has had to reduce its expenditures, as have all of the service units in the Aberdeen area. But, since that budget was never historically based on actual need, it was just an historical accident that the service unit is at the level that it is now. The budget cuts have presented some severe problems to Fort Berthold and to the tribal members. There has been a limit on overtime. Overtime has been increasingly important because the tribe has added two family nurse practitioners to serve in two of the rural communities. So, the lab work and the X-rays come in late and only one lab technician is employed there. The service unit director has decreased training and only uses that training when so directed by the area office or above. Travel has been monitored.

Three GSA vehicles have been returned, including the ambulance. It became increasingly difficult for the service unit to utilize that ambulance with the decrease in staff and with the decrease in funds. Supplies have also been cut.

In an attempt to save funds in the past fiscal year, travel was reduced by $5,000; drugs and medicine by $15,286; supplies by $2,492, making a total saving of $22,778. But, with all these reductions there were still additional costs, and $40,000 additional was needed to meet the costs of that service unit.

At this time there are several crucial vacancies in the service unit. One is the community health nurse, and community health nurses are crucial if you want to deal with the problems in maternal and child health and reduce infant mortality.

The physician assistant position, which served the most rural community, Twin Buttes, is vacant and will not be filled due to the budget reductions. The mental health technician position also will not be filled.

In a recent survey, over half of the children under 16 years old were identified as needing some kind of service in the mental health area, and with the added problem of alcoholism on Fort Berthold, this position is crucial.

Also, staff are being diverted in the area of social services to assure third-party payments, so that the budget can be extended. It is my understanding that medicare and medicaid funds now will not be used to provide improvements on the service unit, but will become a part of the budget. This will cause added stress on Fort Berthold.

A medical technologist is needed if we are to receive accreditation for the Indian Health Service unit. We have limited funds for overtime lab work, which is crucial to diagnosis of illness.

The Three Affiliated Tribes employ about 23 people. We have left, after the many changes that have occurred, a physician extended program which employs two family nurse practitioners and two medical records technicians. The budget for that is $72,355. The funds are only for employees. We have no additional funds in that, so we cannot provide continuing education. The nurse practitioners travel at their own expense to meet with the Indian Health Service, and we have no possibility, if this contract is not increased, of providing salary increases.

The salaries that we provide for the family nurse practitioners are less than the salaries that Indian Health Service provides to the physicians assistants that they employ. Physicians assistants have lesser preparation and narrower perceptions of needs of illness and health in the communities.

The alcoholism program is funded at $49,798, and this year we received $25,000 from community development funds. That will last only this year. The community development funds will only last this year.

Unless we can receive additional funds, we have no way of assuring that we can continue the rehabilitation center. The rehabilitation center provides coordination and after care and assists families with problems of alcoholism in the community.

The community health representative program reduced the budget from over $118,000 to $115,000. It employs 14 people. When we were instructed that those programs would close, all those people were placed on vacation in the event we would have to discontinue this program. This presented a terrible hardship in the community, especially in that we have many elderly people who have no other source of assistance.

And, we had no cost-of-living increases in those contracts, and one-half of our employees who had been employed many, many years by the tribe did not receive a raise this year. We desperately need home health services for the elderly and the handicapped. We have about 150 people who are over the age of 60, and many of them are homebound.

I would just like to comment on the Indian Health Service area office. Since Eleanor Robertson has been the area director, we have had information provided us that we have had good service from that area office in many areas. We have looked at the kind of consultation that has been provided, and we recognize that some of it is a handling type of consultation, and we suggest that those people who would fit in that category would be the CHR coordinator from that area office, and that we feel that the need for the tribal affairs special offices is gone and those offices well could be deleted.

We feel that in order to meet the needs of our people, that the central office and the area office need to drastically decrease their staffing. We would suggest that the research and development office in Tucson be closed, and that the Albuquerque staff, which I do not know a great deal about, also be deleted, and that services directly to tribal members be the priority.

I would just like to read from a GAO report that was provided to us this year. IHS management attention is frequently diverted from places where it is needed most—the service unit and the reservation. Communications, data system, money and staff need to be focused and be responsive to the people where real life and death decisions are made. Thank you.

Senator MELCHER. Thank you very much.

The material you submitted will be made a part of the record at this point. Testimony resumes on p. 174.

Testimony of the Mandan, HidaTsa and ~~Anckara~~ Arickara Tribes, Three Affiliated Tribes, presented at the Senate ~~Subcommittee~~ Select on Indian Affairs Oversight Hearing December 21, 1981, in Billings, Montana, by Reba Walker, Nurse Consultant.

INTRODUCTION

The Mandan, Hedatsa and Arickara Tribes reside on the Fort Berthold Reservation in west central North Dakota. The Reservation boundaries are: Township 152 North (north boundary), Township 146 North (south boundary), Range 95 (west boundary), Range 87 West (east boundary). The 98,815 acre reservation lies in six counties: McLean, Mercer, Dunn, Mountrail, McKenzie and Ward. The reservation has five political subdivisions called segments which are called by their location: North, Northeast, South, West and East. Three of the segments each have a community with a school, housing projects, churches and a community center. The Indian communities are: Mandaree (West), Twin Buttes (South), White Shield (East), while non-Indian towns are found in the North and Northeast segments. The towns are New Town and Parshall respectively. The West and South segments are rolling prairie used primarily for grazing livestock. The Badlands of North Dakota begin where the Little Missouri empties into the Missouri River impinging on the South and West Segments.

The Missouri River (Lake Sakakawea) flows through the heartland of the reservation and is dammed at Riverdale, North Dakota. This immense body of water further divides the reservation with only one bridge, located near New Town, connecting the entire reservation. (Attachment A)

Residents of Fort Berthold purchase most goods and services outside the reservation. Tribal members travel from 35 to over a hundred miles when hospitalization is required. Indian Health Service authorizes hospitalization at the Air Force Hospital in Minot as well as the hospitals in towns surrounding the reservation. (Attachment B)

According to the Bureau of Indian Affairs June, 1981, report of Labor Force 3, 194 Tribal members reside on the reservation and 1,757 are sixteen years or older with the following distribution:

16 to 24 years	666
25 to 34 years	404
35 to 44 years	266
45 to 64 years	315
65 years and over	106

Of the 1,757 Tribal members of working age, 1,232 were potentially employable and 454 of that work force was, at that time, employed. 44% of those employed earned less than $5,000 a year and 63% (788) were unemployed.

PROBLEM STATEMENT

Although the obligations of the Federal Government are to protect the land base and also to provide health and social services to the Mandan, Hidatsa and Arickara Tribes has been stated and restated many times, the delivery of these services has been erroded through the years. In recent times the Three Affiliated Tribes lost over a third of its prime farm land so that one of the many dams could be built just below the Fort Berthold Reservation. It is interesting that the dams placed on the Missouri, by the Army Corps of Engineers, were situated so that Indian reservation lands were flooded. The Three Affiliated Tribes not only experienced increases in alcoholism, depression and violence as a result of the loss of land and displacement of ~~committies~~ communities but also lost the small hospital at Elbowoods.

Over three years ago a new leadership group assumed responsibility for the Tribal Government and has attempted to stabilize the government, develop services, protect natural resources and utilize the skills and abilities of its own Tribal members. As a result, Tribal programs have been stabilized and strengthened. However, the policies of the Regan Administration have reduced the services which the Tribe had developed. As a direct result of these policies, approximately 70 Tribal employees had to be terminated, leaving about 150 Tribal employees.

The increase in unemployment coupled with the anticipated further decrease of health maintenance and illness care funds, presents the Three Affiliated Tribes with serious problems. Increases of the acute problems related to alcoholism, Social problems such as spouce abuse and child abuse, and problems of depression can be expected to increase drastically in the coming months and years - as long as Regan's policies persist.

The health services provided by the Indian Health Service Unit and Three Affiliated Tribes have always been plagued by the lack of funds. Resources which might suffice on a reservation which does not have the extreme isolation of the communities due to the long distances of travel, are and\have, historically, been inadequate on Fort Berthold. It is difficult to recrute and retain professional staff in this setting. Since Indian Health Service funding for each reservation is based on past history, rather than taking into account these unique characteristics, it has been impossible to provide quality illness care and health maintenance to the enrolled Mandan, Hidatsa and Arickara Tribe members.

Quality of care requires professional staff who will stay for a long period of time, adequate diagnostic equipment and space to provide services, also contract care funds. Reservations with hospitals usually don't lose their staff positions when budget problems occurr, but reservations such as Fort Berthold ~~militant~~ without hospitals suffer from loss of contract health services.

The illnesses and conditions requiring care are identified by the information provided by Indian Health Service. In 1980 IHS reported the ten leading causes of hospitalization at Fort Berthold. They are as follows:

1. Diseases of respiratory system
2. Injuries and poisoning
3. complications of pregnancy, childbirth, & puerperium
4. Diseases of digestive system
5. Symptoms, signs, & ill-defined conditions
6. Mental disorders
7. Diseases of circulatory system
8. Diseases of genitourinary system
9. Endocrine, nutritional & metabolic disorders
10. Diseases of nervous system and sense organs

Also reported were the conditions seen in the out patient clinics. They are as follows:

1. Supplemental
2. Diseases of respiratory system
3. Endocrine, nutritional & metabolic disorders
4. Diseases of circulatory system
5. Disease of skin & subcutaneous tissue
6. Accidents, poisonings & violence
7. Musculoskeletal system & connective tissue
8. Diseases of digestive system
9. Infective & parasitic diseases
10. Symptoms & ill-defined conditions

Morbidity related to alcoholism in 1977 as reported by Indian Health Service indicated that 58 (9.0%) of the 643 outpatient visits reported first visit injuries related to alcohol use. The nature of injury of these 58 cases and percentage of each type of injury is:

Fracture of skull	14.3%
Fracture of extremity	8.6%
Dislocation/sprain/strain	3.2%
Injury to eye	14.3%
Laceration/open wound	15.7%
Superficial injury/contusion	9.9%

In 1977 there were 91 new cases of alcoholism diagnosed with 58 of the new cases occurring between ages of 25 and 44 years and 20 of the new cases were diagnosed for individuals between the ages of 45 and 64 years. There were 11 new cases in individuals between the ages of 15 and 24 years. The increased number of diagnosed cases in the 15 to 24 year age group is most disturbing. According to the Child Welfare Program Director, over 90% of the clients served by the Child Welfare program during the past year were alcohol related.

In 1979 Indian Health Service reported nine (9) attempted suicides amoung youth under 21 years of age and two successful suicides in the same age group. A survey conducted in 1980-81 by the Tribal Health Planner identified 716 children in need of mental health services on Fort Berthold. According to the Bureau of Indian Affairs there are 1,437 children under 16 years of age. (See attachment C)

The Three Affiliated Tribes currently contracts with Indian Health Service to provide health services through the following programs: Physician extender, alcoholism, and Community Health Representative. The Tribes Tribal Planning and Development program was defunded at the close of fiscal year 1981. The fiscal year 1982 contracts with Indian Health Service were funded (direct costs) at the following rate:

Physician extender	$ 72,355
Alcoholism	49,798
Community Health Rep.	215,600

Reduction of funds in these programs, which are operating at the same levels as they were in the past, would greatly reduce the services to a population in which needs for services is expected to increase. Inflation rates could not even be considered when these budgets were prepared at the ceiling IHS provided. At least half of the Tribal health employees did not receive salary increase due to budget limitations although the cost of living continues to increase.

The CHR program provides generalized home visits, assists CHN's in well child clinics and provides transportation to health facilities when no other source is available. Services for the prevention and follow-up of specific infectious diseases are also expected to be provided. Although specific services to the elderly are to be provided it has been difficult for the CHR program to meet the responsibility. The program staff is composed entirely of paraprofessionals. Some CHR's have received training from IHS while other have not. The CHR's in one isolated community are the only health related personnel available. (IHS was unable to retain a physician assistant position for this community with the budget cuts.)

The Tribes alcohol rehabilitation program is staffed by paraprofessionals who arrange clients participation in Alcoholics Anonymous, arrange treatment at the state and V. A. hospitals, and provide transportation to these facilities. The paraprofessional staff is not prepared to conduct group therapy; however, the counselors do provide one to one counseling and informal group discussions do occurr. The Three Affiliated Tribes were successful in the competition for IHS Community Development funds. The $25,000 supplements the alcoholism this year and funds some of the staff; however, these funds will not be available in fiscal year 1983.

The alcohol problem among both youth and adults is increasing on Fort Berthold and additional funds are needed to either recruit qualified personnel or provide training for the paraprofessional staff. Until this occurrs the Tribe will be unable to receive third party reimbursements for the services provided at the Alcoholism Rehabilitation Center.

The Tribe has one program which is staffed by health professionals who provide direct service in two communities (White Shields and Mandaree). The Physician Extender Program employs two Family Nurse Practitioners who live in these communities and maintain the IHS Clinics located in those communities. Recruitment for this contract was extremely difficult and it took one year to staff both positions. The contract also includes a medical records clerk in each of these communities.

The placement of nurse practitioners in these communities has increased the use of the Service Unit diagnostic staff and facilities. The laboratory staff of one and x-ray technician now have additional work because of the high utilization of these two clinics. Not only is staff stressed by over work but IHS budget restrictions affect the overtime funds available for these personnel. The laboratory and x-ray equipment is old and in constant need of repairs.

Indian Health Services professional staff turnover does not allow for continuity of care. The FNP are able to provide adequate health assessments and assure continuity of care.

The IHS Service Unit on Fort Berthold is on a severly limited budget. The physician assistant and community health nurse positions have been left vacant and it is extremely difficult to maintain adequate supplies and pharmaceuticals to meet client needs. The Minne Tohe Service Units' needs for funds to purchase adequate diagnostic equipment and supplies is not new, it just becomes more critical with the increased demands due to the Tribe Physician Extender Program, and the cuts imposed by the administration. The Service Unit needs to develop an automated medical record system, utilizing computor technology, so that records are readily available in each of the clinics, or hire additional medical clerks to maintain the same records in each community. A computerized system could assist in providing comprehensive service, including reports of referral physicians and follow-up treatment.

Although the Service Unit budget has been reduced, HSA required that an employee from a southern hospital, which was recently closed, be transferred at IHS's expense to Fort Berthold and that individual salary he paid while also paying the salary of the individual currently occupying the position. It is unknown who in Indian Health Service agreed to use those funds to assist displaced personnel from another agency.

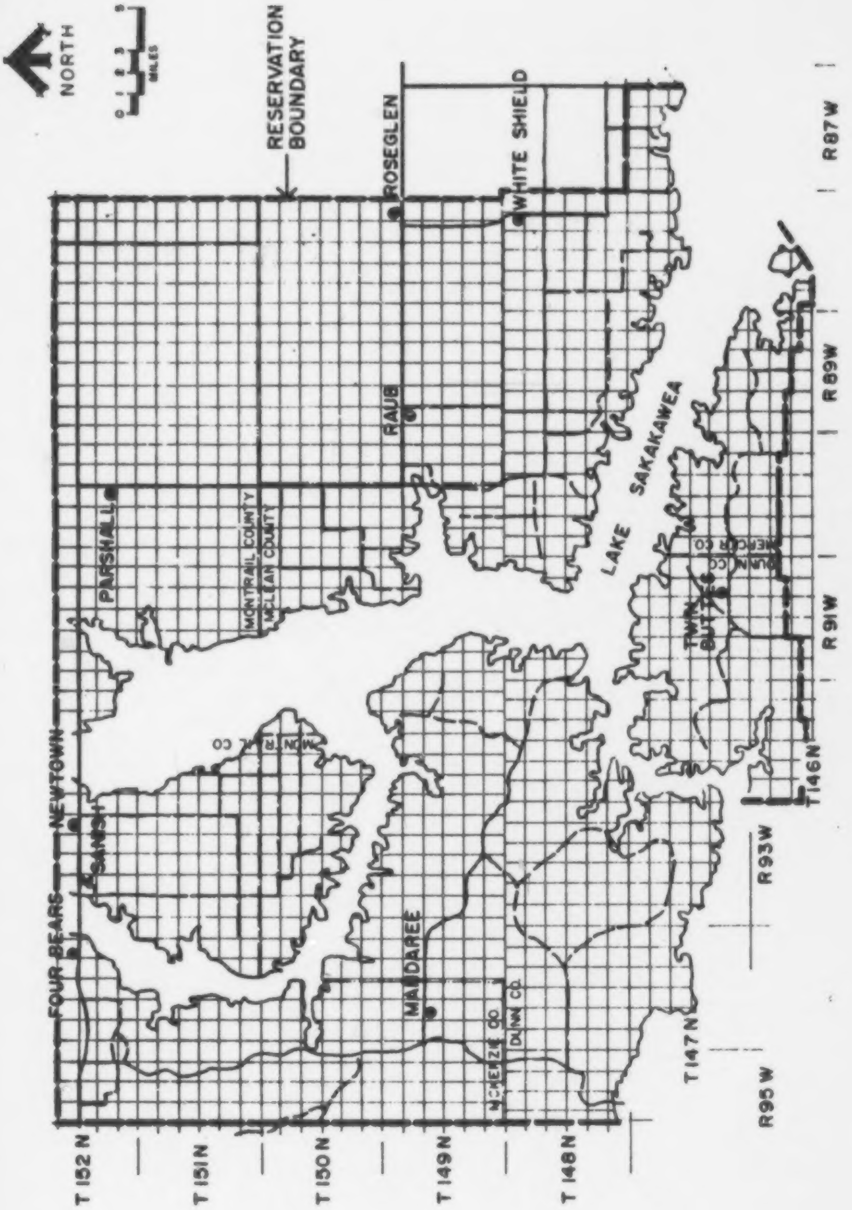
The need to increase contract care funds so that people can be hospitalized when necessary is critical. Since the hospital was removed in tne 1950's, the need for hospitalization in Fort Berthold has never been met adequately. People travel far from home for treatment and their families are often unable to accompany them then the sick individual most needs the emotional support of the families.

CONCLUSIONS

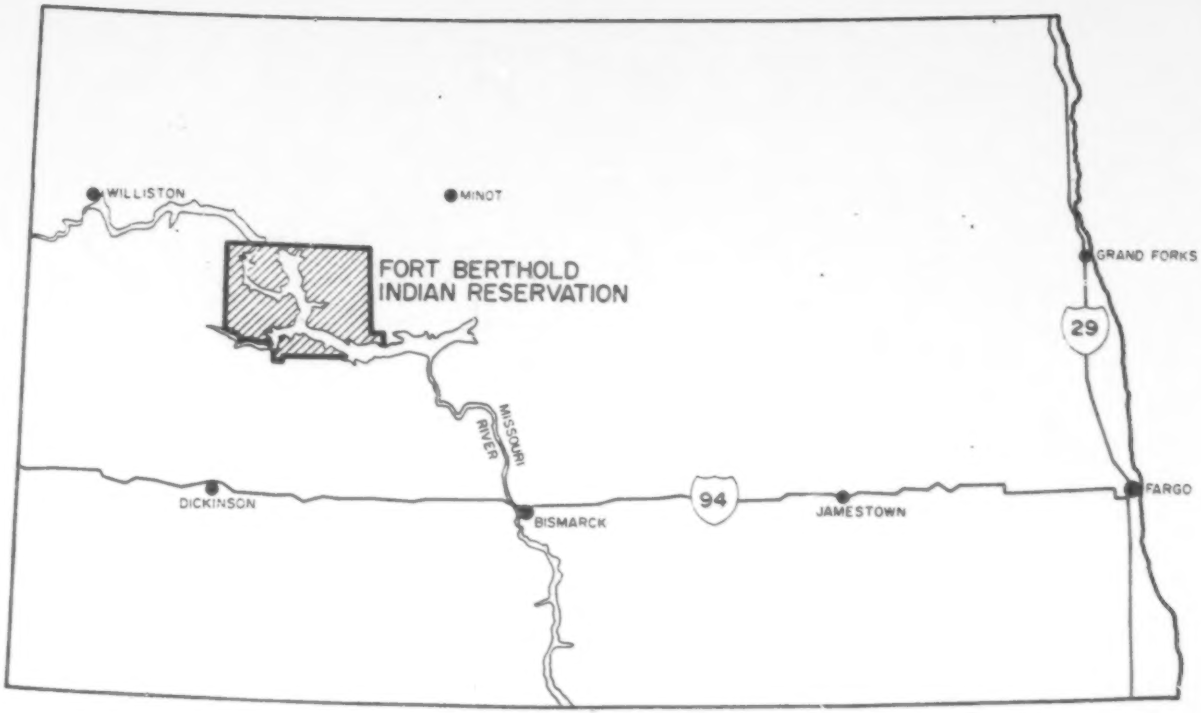
The Three Affiliated Tribes cannot attempt to alleviate the needs for health maintanence and illness care if the Tribes and IHS Service Unit budgets are reduced.

According to the recent GAO report on IHS "...IHS management attention is frequently diverted from places where it is needed most -- the Service Unit and the Reservation. Communications, data systems, money and staff need to be focused on and responsive to the people who are on the spot, where real life and death decisions are made."

The budget cuts need to be absorbed by IHS on the national and area level including their extentions in Albuquerque and Tuscon.


NORTH
0 1 2 3 5
MILES
RESERVATION BOUNDARY
ROSEGLEN
WHITE SHIELD
RAUB
PARSHALL
MONTRAIL COUNTY
McLEAN COUNTY
LAKE SAKAKAWEA
MERCER CO.
DUNN CO.
TWIN BUTTES
FOUR BEARS
SANISH
NEWTOWN
MONTRAIL CO
MANDAREE
McKENZIE CO
DUNN CO.
T 152 N
T 151 N
T 150 N
T 149 N
T 148 N
T 147 N
T 146 N
R 95 W
R 93 W
R 91 W
R 89 W
R 87 W

FORT BERTHOLD RESERVATION


WILLISTON
MINOT
FORT BERTHOLD
INDIAN RESERVATION
GRAND FORKS
29
MISSOURI
RIVER
DICKINSON
BISMARCK
94
JAMESTOWN
FARGO

NORTH DAKOTA REGION MAP

SCALE: 0 5 10 20 50 MILES

SURVEY OF MENTAL HEALTH NEEDS IDENTIFIED BY AGENCIES, SCHOOLS AND LAW ENFORCEMENT ON FORT BERTHOLD 1980

SCHOOLS	Mood Changes	Behavior Problems	Alcohol Problems	Emotional	Drug Abuse	Handicap	Dental	Suicide Attempts	Suicide	Mental Health Referrals all Categorized	Arrests	Totals
MANDAREE						8				60		68
NEW TOWN HIGH SCHOOL*		10%	10%	10%				1				1
NEW TOWN ELEMENTARY	10	4		10		9						33
HALLIDAY HIGH SCHOOL	1	4	2			1						8
TWIN BUTTES SCHOOL		1	1			10						12
PARSHALL HIGH SCHOOL*	40%	4	15%	20%				5				9
WHITE SHIELD SCHOOL		25%				9						9
ALL HEAD START				1		16	17					34
INDIAN HEALTH SERVICE								9	2	252		263
CHILD WELFARE	3	11	4	7	3							28
LAW ENFORCEMENT+		6	15								230	251
TOTAL	14	30	22	18	3	53	17	15	2	312	230	716

*New Town High School 150 Indian Students, Total Enrollment 300.
*Parshall High School 48 Indian Students, Total Enrollment 189.
+Arrests for violating curfew, running stop signs, reckless driving, fleeing from police officers, driving without license, driving while under the influence of alcohol, forging checks, and destroying private property.

NOTE: Percentages are not included in totals.

F

Senator MELCHER. Our next witness will be Mike Welsh.

STATEMENT OF MIKE WELSH, DIRECTOR, MONTANA UNITED INDIAN ASSOCIATION, HELENA, MONT., ACCOMPANIED BY BEN BUSHY HEAD, EXECUTIVE DIRECTOR; ERNIE BIGHORN, DEBBIE CUNY, CAROL O'NEIL, CAROL OWENS, AND SUSAN TALL BULL

Mr. WELSH. Senator Melcher, I am Mike Welsh, director of the United Indian Association. I noticed on the schedule here you promoted me to executive director, but our executive director is sitting to my left, Ben Bushy Head.

Senator Melcher, distinguished guests, the Montana United Indian Association is appreciative of this opportunity to testify today regarding the import of proposed budget reductions and allocations of budget cuts. I have with me today Ernie Bighorn, Debbie Cuny, Carol O'Neil, Carol Owens, and Susan Tall Bull. I will keep my verbal testimony short so they may also speak.

The Montana United Indian Association represents more than 17,000 urban Indian people living in the cities and towns of Montana. The MUIA's alliances have been instrumental in the health care and the provision of primary care services to the burgeoning urban Indian population.

Although it is true that the U.S. Congress, the Indian Health Service, and the Montana State Legislature have all recognized the importance of Montana's urban Indian health programs, Mr. Reagan continues to push for more cuts from social service programs. In addition to federally inspired cuts, there appears to be little agreement among the several very large, phase IV clinic operations on how they plan to utilize the $8.16 million appropriated for urban Indian health projects in the Interior bill, which has not yet been signed. Rumors abound to the effect that since Montana's projects, taken individually, are relatively small, they should be discontinued. Obviously, we do not agree. Collectively, our health programs provide primary care to an Indian population comparable to that of the largest urban areas.

The MUIA has the documentation, enclosed in the 42-page document given to the committee which, in addition to the testimony of the individual programs, fully justifies our programs' continuation. In an October 2, 1981, letter to Ms. Linda Richardson of the Senate Interior Appropriations Committee, which is attached to this testimony, the MUIA fully addressed the necessity of maintaining Montana's clinic projects and emphasized Montana's unique need for transportation and referral alliances. We also suggested an evaluation plan to be used in determining which projects should retain funding by reason of service delivery, effectiveness and efficiency, which we understand was incorporated in the Interior bill.

The MUIA's health funds from the Indian Health Service for calendar year 1981 totaled $260,730, of which the administrative cost of the contract was $43,762, or an extremely frugal 16.8 percent—3.2 percent below the Federal recommendation of 20 percent. It is our position that the costs associated with the program's administration should be carefully scrutinized without sacrificing or compromising programming funds. MUIA's health request to the Indian Health Service for fiscal year 1982 funding proposed a "bare bones" administrative percentage of 17.8 percent in spite of dramatic increases in inflation. It is the MUIA's position that emphasis must be placed upon service delivery as opposed to perpetuating administrative personnel.

Should you have any questions relative to our testimony, representatives of the MUIA are at your disposal.

Is Ernie Bighorn here? Ernie, did you want to speak?

Mr. **Bighorn**. I do have some written testimony, but to save some time, I will just submit it for the record.

Ms. **Debbie Cuny**. My testimony is written, also.

Ms. **Carol Owens**. Due to the length of my testimony, I should like to submit it.

Ms. **Susan Tall Bull**. I would like to submit my testimony.

Senator **Melcher**. Thank you, very much. All of the material submitted by your panel will be made a part of the record at this point.

[The material follows. Testimony resumes on p. 261.]

MUIA U.S. SENATE OVERSIGHT DATA

1-2 History and Background of MUIA and P.L. 94-437
3 Effectiveness of Urban Indian Health Centers
4-5 Duplication of Services
6 Preventive Health Contrasted with Primary Health Care
7 Health Fact Sheet
8 FY 80-81 Funding From Indian Health Service
9 Distances To Reservations - One Way
10-11 Information Requested By Sub-Committee #2
12-17 Federal Register, Vol. 43, No. 151 - Friday, August 4, 1978
16-17 "On or Near" Policy and 180 Day Rule
18-24 Address to The Montana House Appropriations Committee
25-26 Letters To Montana State Senator Ed Smith Re: Reservation Medical Service
27 U.S. Senator Max Baucus' Address to Congress Re: Urban Indian Health programs
28 U.S. Representative Pat Williams Letter to Representative Yates
29 U.S. Representative Pat Williams Letter to Representative Yates
30 U.S. Senator John Melcher's Letter Re: Urban Indian Health
31 U.S. Representative Ron Marlenee's Letter Re: Urban Indian Health
32-36 Newspaper Articles
37 Transcript of KTVG Interview 11-13-81
38-42 Address To The Finance And Claims Committee

The Montana United Indian Association (MUIA) was incorporated in 1971 as a non-profit organization representing urban Indians throughout the state of Montana. Eight local Indian alliances and the MUIA joined forces to create a consortium to provide needed services in their respective communities. Those alliances were: Anaconda, Billings, Butte, Great Falls, Havre, Helena, Miles City and Missoula.

Seven alliances currently offer services to the urban Indian population which include health care, housing, job placement assistance, educational opportunities, outreach, transportation, mental health counseling and other supportive services.

The MUIA central office, located in Helena, is responsible for the administration of state and federal programs. MUIA provides technical assistance, guidance, counseling and advocacy for the consortium and the estimated 16,000 urban Indians of Montana. A major responsibility of the MUIA is to procure funding to continue existing programs and to expand services to the urban Indian population of Montana.

In the past the MUIA has successfully obtained health funding from the Indian Health Service as a result of Public Law 94-437, "The Indian Health Improvement Act." As a result of this legislation passed in 1976, the alliances were enabled to provide the following services:

* A data needs assessment
* Establishment and provision of direct medical care on site
* Removal of the multiple barriers accessing health care
* Provision of preventive health care education

Public law 94-437, Title V, Section 501, The Indian Health Care Improvement Act, reads "The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population;" the Congress of the United States, recognizing the severity of the urban Indian Health status, passed the public law to ensure health services provision.

Since reauthorizing Public Law 94-437 in 1980, the Congress has been exhorted to indiscriminately cut social service programs regardless of need or their accomplishment. The Office of Management and Budget (OMB) has issued several misstatements of fact about urban Indian health organization, namely "Urban Health projects largely provide referral, rather than medical, services; (they) are not required by treaty obligation; and (they) are over and above services available to the general population." In the detailed Health Proposal for fiscal year 1982, we successfully address these "artificial" issues. The documentation that follows is a skeleton outline of the needs and accomplishments of Urban Indian Health Centers.

You should be acutely aware of the life and death ramifications of immediate access to quality health care. Urban Indians face deprivation of urgently needed health care services every day. The efforts of urban Indian health care professionals will be for nought if projected cuts of one hundred percent elimination in Fiscal Year 1982 are enacted.

Program Narrative and Budget Request
Page 2. (continued)

(2)

The Health Advisory Committee of the Montana United Indian Association has prepared the following data summary for your personal attention: Indian programs will suffer a disproportionate share of the proposed budget cuts. Indian programs, which account for only .4% of the total Federal Budget, would absorb nearly 3% of the national budget cut.

It cannot be disputed that American Indian people are the neediest of Montana's poor. In this, the most affluent country in the world, Indian people rank at the bottom of every social and economic statistical indicator:

- lowest per capita income
- highest unemployment rate
- lowest level of education
- shortest lives
- worst health conditions
- poorest housing
- highest suicide rate
- family poverty 300% greater than national average

Contrary to OMB justifications, Block Grants to states will not guarantee provision of Urban Indian Health Care Services to our population. All of the truly remarkable accomplishments achieved by Urban Indian health care programs in the past five years will be utterly negated - clinics will cease to exist, trained Native American health care personnel will not be able to fulfill their committment to Indian people and, worst of all, another successful Urban Indian program will be eliminated precisely at the moment of fruition.

We can no longer look to the Federal Government to meet all our financial needs. Proposed budget cuts from the Reagan Administration will zero out urban Indian health care in Fiscal Year 82. We are requesting financial support from the State of Montana so that the MUIA may continue its commitment to all urban Indians in the State of Montana.

(3)

THE EFFECTIVENESS OF UTILIZATION OF URBAN INDIAN HEALTH CENTERS

Urban Indian Health Care Centers are a vital key to meeting the health needs of urban and rural non-reservation Indians. In meeting those needs, Montana's urban Indian health centers have demonstrated an ability to be:

- cost effective and well utilized.
- developing and/or maintaining a quality assurance program
- improving the health status of American Indians
- developing linkages with other providers

I. Cost Effective

In a study on several health centers, it was shown that:

- per patient costs are lower than national norms
- $19.50 was the average cost of a patient encounter
- health care centers can deliver quality care at reasonable costs. Last year's average administrative costs was 19.74%, below the 20% criteria
- for every dollar of Title V funds, a dollar or more was matched by other sources of revenue
- financial audits have indicated strong financial management
- productivity rates are in keeping with standard norms. An average 2.6 patient encounters per hour was maintained by several of the health centers

II. Utilization

Urban Indian Health centers have shown a marked increase in medical and dental encounters over the years and are leveling off at full productivity. Since 1979, the health care centers have had an average 55 percent overall increase in services provided. This remarked increase is attributed to:

- institution of more comprehensive health services where none existed before. More health centers have moved from Phase II to Phase III, increasing the level of health care.

- Changing patterns of utilization of expensive episodic health care (emergency rooms, hospitalization, for preventive diseases) to prevention and early intervention primary care.

III. Quality Assurance

Initiative has been taken by the health centers to improve and maintain a high degree of professional training and responsibility. This is being achieved by:

- peer review
- on-going continuing education
- implementing of services, where careful review has shown a need
- patient evaluation of centers
- treatment compliance reveiw process

IV. Improving the Health Status of American Indians

In the past American Indians have been the victim of non-existent or poor medical-dental services. Consequently Indians suffered from a higher death rate, higher infant death rate, and higher preventable death rate.

- statistics have shown that the death rate of Indians is 841.4 deaths per 100,000, this in contrast to the overall USA population which is 606.1 per 100,000.

Montana United Indian Association

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Helena, Montana
59601

MUIA

MONTANA UNITED INDIAN ASSOCIATION POSITION PAPER

DUPLICATION OF SERVICES

By far the most controversial aspect of Minority oriented social service programs is the question of duplication of services, or in the jargon of the bureaucrat, "duplicative" services.

Opponents of urban Indian health programs are fond of loudly and persistenly exclaiming that these programs duplicate services available to "everybody" through "private sector" health care providers. This issue has become an emotional area since detractors of the program's progress make the claim without examining the facts.

Fact: The United States Government policy of relocating reservation Indians to the country's urban and rural areas in 1952 left those people in a "limbo" status insofar as health care provision is concerned. There were no health care services waiting for the relocated Indian people. Indians who have lived off-reservation for 180 days are no longer eligible for health services. The Indian Health Service does not universally care for all Indian people. There is no "Indian Insurance Card" which will provide free health care to urban or rural Indians. Where "free" health care has been provided through Public Health Service projects and charitable institutions, blatant discrimination has caused extreme resentment among Indians. A person should not have to suffer degradation at the hands of tax supportive institutions' personnel in order to secure health care. The public blithely assumes that Indians' health care is provided for ... this is not the case.

Fact: Public Law 94-437, reauthorized by the Congress of the United States in 1980, states categorically that: "The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population." In the opinion of the 94th and 95th Congresses of the United States, urban Indian health programs are not duplicative.

Fact: The American Indian Policy Review Commission in their "Report on Indian Health," does not see urban Indian health programs as duplicative since they recommend that: "Congress appropriate sufficient funds for the continuance of present Indian centers in urban areas which assist Indians in obtaining medical ... services; and should encourage, with funds and guidance, the establishment of additional such centers in all urban areas where Indians live."

Fact: Health Departments in many states recognize the necessity of urban Indian health centers and contract with them for delivery of services to the Indian population that would not otherwise be provided at all. This would not occur if the states considered these programs duplicative.

Fact: Transportation and referral alliances provide urban people with the means of accessing health care. It is hardly a duplication of services to transport Indian people to a health care provider since no alternative exists.

Fact: If a patient does not have the financial resources to visit a private provider of medical care, that provider will cease to deliver services. It is not then duplicative to provide medical services to that patient.

Fact: The American Public Health Association (APHA) has acknowledged the severity of (urban) Indian health in their meetings on November 1 through November 5, 1981. The opinion of the APHA is that these programs are not duplicative.

Fact: Preventive health provision in lieu of episodic and emergency room usage reduces duplication by eliminating an increasing burden on the taxpayer. In this sense, the programs are financially non-duplicative and cost-efficient.

Therefore, it is apparent that urban Indian health programs do not duplicate services, but provide medical services where none have existed before and at a lower per patient rate than available in the private sector.

References: Montana Senator Max Baucus
American Indian Policy Review Commission
American Public Health Association
State of Montana Department of Health
The Congressional Record - October 27, 1981
California Urban Indian Health Council
Montana United Indian Association

(6)

MONTANA UNITED INDIAN ASSOCIATION

1) We understand that information has been given to the Committee to effect that public clinic services are available to the general public and therefore urban Indian individuals. According to John Bartlett, Deputy Director of the State Department of Health, only the following preventive services are available in the context of public preventive health:

(1) well child clinic
(2) women, infants and children
(3) child nutrition
(4) hypertension programs*
(5) VD screening & control
(6) family planning*

These programs are strictly education & prevention.

*Indian participation

2) No primary care services such as:

MUIA Clinics provide all of these services.

(1) physical exams, prenatal & school screening exams
(2) minor surgery
(3) acute & episodic treatment for strep throats, broken limbs, flu, EKG monitoring, routine lab services, otitis media, etc.
(4) surgical referral
(5) anemia screening
(6) diabetic screening
(7) contract pharmacy services
(8) home nursing visit
(9) post surgical treatment
(10) total primary diagnostic services
(11) plus all preventive services noted in 1) above.

HEALTH FACT SHEET

OCTOBER, 1980 to SEPTEMBER, 1981

	GREAT FALLS	HELENA	MISSOULA
PULATION SERVED	11,651	7,291	1,785
VICES PROVIDED*	(4) contracting physicians Hypertension Screening Urinary Screening Physical Exams Diet Counseling Diabetic Counseling Nutrition Counseling Transportation Prescriptions Referral	10,191 Services Provided: Outreach Transportation (2) Contracting Physicians Nurtition Counseling Physical Exams Hypertension Screening Referral Elderly Nutrition Prescriptions Contracting Dentists Urinary Screening	Outreach (2) Contracting Physicians Prescription Services Dental Exams Optometric Exams Nutrition Services Preventative Outpatient Care
ALTH EMPLOYEES	Health Director Registered Nurse Medical Assistant	Health Director Registered Nurse Receptionist	Health Director Health Outreach Worker Clinic Receptionist (9 month period only)
RCENT OF ELDERLY	3%	25%	17% Average = 14.25%
PER ENCOUNTER	$7.13**	$19.50	$17.60

* Total number of services provided during FY 81 is 21,327

** Represents the average of all services provided; the cost per patient for the three clinics averages $18.08

EXHIBIT C

Montana United Indian Association

(8)

Phone
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Helena, MT
59601

M U I A

November 10, 1981

Chairman Burt Hurwitz
Legislative Committee #2
Room 104
State Capitol
Helena, MT. 59601

Dear Chairman Hurwitz:

This letter is written in response to requests for additional information from your committee members.

Senator Wolf requested a breakdown of last year's Indian Health Service funding and the relative percentages delineated below:

FY 1981
INDIAN HEALTH SERVICE CONTRACT

ALLIANCE	
Anaconda	$22,619.00
Butte	$22,619.00
*Great Falls	$83,092.00
*Helena	$39,266.00
Miles City	$22,122.00
*Missoula	$34,845.00
Montana United Indian Association (MUIA)	$43,762.00
FY 79'-80' Supplemental Carry Over	$32,336.00
GRAND TOTAL	$321,815.00

*Clinic Alliances

Given the awesome inflationary trends in the field of medical service provision, the MUIA's total budget request to the Indian Health Service (IHS) for Fiscal Year 1982 was $461,412.00. MUIA's request to the State for funding alternative #1 ($345,000) equals a 25% cut from the IHS request.

MUIA IS AN EQUAL OPPORTUNITY EMPLOYER

BILLINGS AMERICAN INDIAN COUNCIL
BILLINGS MONTANA

NORTH AMERICAN INDIAN ALLIANCE
BUTTE MONTANA

GREAT FALLS INDIAN EDUCATION CENTER
GREAT FALLS MONTANA

HELENA INDIAN ALLIANCE
HELENA MONTANA

MISSOULA QUA QUI CORPORATION
MISSOULA MONTANA

HILINE INDIAN ALLIANCE
HAVRE MONTANA

NORTH AMERICAN INDIAN LEAGUE
DEER LODGE MONTANA

ANACONDA INDIAN ALLIANCE
ANACONDA MONTANA

NATIONAL ASSOCIATION OF
BLACKFEET INDIANS

Alternative #2 equals a 38.3% cut from that request.

Since the actual funding received from the Indian Health Service for FY'81 equals $321,815, funding alternative #1 to the State Legislature equals an extremely modest 7% increase; alternative #2 equals an 11.5% decrease over last year's actual funding.

In response to Senator Van Valkenburg's question asked on November 9, 1981 regarding why all these clinics were proposed to be funded at $75,000 each, one can see that Great Falls received a larger share of the monies to upgrade their clinic operations in FY'81. Likewise, Helena had previously received improvement funds from a one-time source called Norton-Sound monies. Therefore, it is the MUIA's position that Missoula should be allowed to achieve parity with the other two clinics. However, the budget could be restructured if so desired.

Vice-Chairman Smith cited an example (near Fort Peck) of Indian people receiving reservation benefits while living off-reservation. The MUIA does not have specific knowledge of this example, but we wish to state that the people we serve through the urban clinics located in Great Falls, Helena, and Missoula are solely urban people who live, work and recreate in Montana's cities. The approximate one-way distances from the nearest reservation to each of the urban health centers is detailed below:

Great Falls to Rocky Boys' = 87 miles
Helena to Flathead = 173 miles
Missoula to Flathead = 61 miles

It is important to note that very few Montanans would drive 174, 346 or 122 miles in the summer to receive Primary Health Care, even if they could afford the gasoline, to say nothing of making the same trip in the winter.

Equally important is the fact that appointments have to be made for the service delivery which many times involve planning weeks ahead. In addition, if urban Indians had the money for the gasoline to travel those distances, they could pay for local non-Indian primary care.

After all of the above stipulations are met, the last hurdle is one of tribal affiliations; the tribe's ability to absorb twice as many patients (even if they wanted to) in this year of budget cuts.

The MUIA wishes to thank you, Chairman Hurwitz, and your committee for allowing us the opportunity to present our proposal and for offering us an eminently fair hearing.

Should your committee require further information relative to our testimony, please contact us at your convenience.

Sincerely,

Mike Welsh
Health Director

Edward Kennedy

Edward Kennedy
Chairman
Health Advisory Committee

Montana United Indian Association

Phone
443-5350

P.O. Box [illegible]
Helena, MT
59601

M U I A

November 10, 1981

Ms. Jan Dee May
Legislative Fiscal Analyst
State Capitol
Helena, Montana 59601

Dear Ms. May:

In accordance with Committee #2 Chairman Hurwitz's directive this date, the attached line item budget represents a model budget for each of the Montana United Indian Association's clinics located in Great Falls, Helena and Missoula.

Should you require any further information, please feel free to contact me.

Sincerely,

Mike Welsh
Health Director

MW/jw

cc: Chairman Burt Hurwitz
Leona Williams
Edward Kennedy
Carol Owens
Sue Schield

MUIA IS AN EQUAL OPPORTUNITY EMPLOYER

BILLINGS AMERICAN INDIAN COUNCIL
BILLINGS MONTANA
NORTH AMERICAN INDIAN ALLIANCE
BUTTE MONTANA
GREAT FALLS INDIAN EDUCATION CENTER
GREAT FALLS MONTANA

HELENA INDIAN ALLIANCE
HELENA MONTANA
MISSOULA QUA QUI CORPORATION
MISSOULA MONTANA
HI-LINE INDIAN ALLIANCE
HAVRE MONTANA

NORTH AMERICAN INDIAN LEAGUE
DEER LODGE MONTANA
ANACONDA INDIAN ALLIANCE
ANACONDA MONTANA
NATIONAL ASSOCIATION OF
BLACKFEET INDIANS

MODEL BUDGET REQUEST
MONTANA UNITED INDIAN ASSOCIATION
HEALTH CLINICS

1. DIRECT LABOR		
Executive Director	20%	$ 3,600.00
Clinic Health Director	100%	15,750.00
Registered Nurse	2080 X 7.69	15,995.20
Clinic Receptionist	2080 X 4.62	9,610.00
2. FRINGE		
17.5%		$ 7,849.70
	DIRECT LABOR/FRINGE TOTAL	$52,805.00
3. MATERIALS AND SUPPLIES		
A. Expendable Clinic Supplies	$166.67 X 12 mo.	$ 2,000.00
B. Office Supplies	$100.00 X 12 mo.	1,200.00
	MATERIALS/SUPPLIES TOTAL	$ 3,200.00
4. CONSULTANTS/SUB CONTRACTORS		
A. Physicians	$50.00 hr. X 5 hr./wk X 52 wks.	$13,000.00
B. Contracted Care Services		
1. Pharmacy	$150.00 mo. X 12 mo.	1,800.00
2. Dental	$150.00 mo. X 12 mo.	1,800.00
3. X-Ray/Lab	$150.00 mo. X 12 mo.	1,800.00
	CONSULTANTS/SUB CONTRACTORS TOTAL	$18,400.00
5. EQUIPMENT/RENTAL		
A. Rent of Office Space	$150.00 mo. X 12 mo.	$ 1,800.00
	EQUIPMENT/RENTAL TOTAL	$ 1,800.00
6. OTHER DIRECT COST		
A. Xerox	$100.00 mo. X 12 mo.	$ 1,200.00
B. Telephone	$175.00 mo. X 12 mo.	2,100.00
C. Training	Continuing Medical Education-R.N.	495.00
	OTHER DIRECT COST TOTAL	$ 3,795.00
	GRAND TOTAL	$80,000.00

NOTE: This budget represents a subsistence level - It excludes optical care and provides minimal contract physician's services.

- 3,000 FOR OPTICAL
- 5,403 CONTRACT PHYSICIANS
5% CUT IN DIRECTOR'S CURRENT SALARY
NO PERSONNEL INCREASES

[4110-84]

Title 42—Public Health

CHAPTER 1—DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PART 36—INDIAN HEALTH

Subpart C—Contract Health Services

AGENCY: Department of Health, Education, and Welfare.

ACTION: Final rule.

SUMMARY: This rule establishes contract health service delivery areas, and uniform eligibility, notice and related requirements for the provision of contract health services to eligible Indians and other beneficiaries within those areas. The purpose is to clarify eligibility and responsibility in the administration of this program.

EFFECTIVE DATE: August 4, 1978.

FOR FURTHER INFORMATION CONTACT:

James Mitchell, Contract Health Services Branch, Indian Health Service, Room 5A-27, 5600 Fishers Lane, Rockville, Md. 20857, 301-443-4700.

SUPPLEMENTARY INFORMATION: On October 22, 1976, a notice of proposed rulemaking (NPRM) was published in the FEDERAL REGISTER (41 FR 46792 et seq.) proposing to revise subpart C of 42 CFR Part 36 to establish contract health service delivery areas, and eligibility and related requirements for the provision of contract health services within those areas. Interested persons were given until December 21, 1976, to submit written comments, suggestions, or objections.

A. CHANGES MADE FROM THE PROPOSED RULES

After full and careful consideration of all comments received, certain provisions of the proposed rules have been revised as noted below:

1. For ease of use the definitions have been placed in alphabetical order.

2. The definition of "alternate resources" formerly § 36.21(i) has been renumbered as § 36.21(a).

3. The term "personal resources" has been deleted from the definition of "alternate resources." Numerous commentors suggested deletion on the basis that: Historically the Indian Health Service (hereinafter, IHS) as a matter of practice, has not applied a means test for services; has not excluded persons from receipt of contract health services because they had "personal resources"; and "personal resources" was not defined. IHS does not, nor does it intend to apply a means test as a condition for receipt of services. Personal resources have, historically, been utilized to assist or supplement the cost of medical care services when funds available to IHS were insufficient to cover the total cost of services provided and the Indian or his tribe had such resources to voluntarily use. This practice may continue in the future when agreed to by the parties involved, but it is felt that inclusion of "personal resources" in the definition of "alternate resources" is not warranted, and has been eliminated. The elimination of this term should also ease the fears of those commentors who consider the term as jeopardizing the unique relationship of the Indian with the Federal Government.

3. A definition of "appropriate ordering official" has been substituted for the definition of "authorizing official" and designated as § 36.21(b). This change was made to accommodate changes made in section 36.24 (discussed later).

4. The definition of "contract health services," renumbered as § 36.21(e), has been changed to clarify that the term applies to services provided by facilities other than those of IHS.

5. As a result of several comments pointing out that § 36.24 would be impossible to administer without a definition of "emergency," such a definition has been added as § 36.21(f). When possible, the decision as to the state of emergency will be made by appropriate IHS medical authority. Otherwise, the decision will be made by the appropriate non-IHS medical authority attending the patient.

6. The definition of reservation renumbered as § 36.21(l), has been changed to that used by the Bureau of Indian Affairs in its regulations governing financial assistance and social services programs (25 CFR 20.1(v)) for purposes of increased consistency and because it is considered more precise.

7. For purposes of clarification, a definition of the work "Service" to mean the Indian Health Service has been added as § 36.21(h).

8 As a result of the decision to designate the State of Oklahoma as a contract health service delivery area (discussed later), a definition of "traditional Indian country," formerly numbered as § 3621(e), is no longer needed and it has been deleted.

9 Due to changes made in § 36.23(a) to reference § 36.12 of 42 CFR (discussed later), the definition of "Indian," formerly designated as § 36.21(f), has been deleted since it is no longer needed.

10. The State of Nevada has been designated a contract health service delivery area in § 36.22(a). This designation is based on a number of comments and tribal resolutions which pointed out that the county option approach would result in an unintended exclusion of an estimated 30 percent to 40 percent of Nevada Indians from IHS contract health services. This result was a factor of both the small size and scattered location of the reservations and colonies in Nevada and the particular social structure of the Nevada Indian population.

11. The entire State of Oklahoma has been designated a contract health service delivery area in § 36.22(a). This is a change from the NPRM which included only traditional Indian country in Oklahoma which, in effect, meant the entire State except for the cities of Tulsa and Oklahoma City. This change is due to the high incidence of utilization of and dependence on IHS facilities by eligible Indian residents of Tulsa and Oklahoma City. Under the NPRM, if eligible residents of the two cities presented themselves to an IHS facility, they would be eligible for care but if the IHS facility for any reason could not provide the needed direct care, the individuals would not be eligible for contract health services. This makes neither administrative nor programmatic sense due to the reliance the affected population places on IHS for health care services.

12. A number of counties in the State of Michigan have been designated a contract health service delivery area in § 36.22(a) This designation was made as a result of a number of comments from tribal representatives which pointed out that the Saulte Ste. Marie Tribe of Chippewa Indians have traditionally occupied a seven-county area where they currently receive contract health services but have tribal land in only one county. The county option proposal would result in an estimated 50 percent of the service population being declared ineligible for contract health services. This would be counter to the intent of the regulation and current service patterns as well as the intent of Congress which provided funding for a seven-county program.

13. An area consisting of 14 counties in the State of Wisconsin and 1 county in the State of Minnesota has been designated a contract health service delivery area in § 36.22(a). This designation was made as a result of a resolution by the Wisconsin Winnebago Business Committee which pointed out that there is no defined reservation area, as such, for Wisconsin Winnebago Indians and that tribal land is scattered over a 15-county area traditionally occupied by the Wisconsin Winnebago people who currently reside on or near those lands.

14. Section 36.22(b), providing for redesignation of contract health service delivery areas, has several revisions. It

has been revised to clarify that only areas or communities "within the United States" may be redesignated as a part of a contract health service delivery area. This clarification was prompted by a number of comments pointing out that there was no specific prohibition to including non-U.S. territory.

Also, as a result of a number of comments, the words "or other Indian" have been deleted from § 36.22(b) to require consultation only with tribal governing bodies with respect to area redesignation. In addition, the words "people native to the reservation" and "members of the tribe" have been deleted from § 36.22(b) (1) and (2) respectively to bring this section into conformity with § 36.23(a) as revised. As revised, § 36.22(b) (1) and (2) requires consideration of the number of Indians (not just those native to the reservation) in the proposed area and the social and economic affiliation of those Indians with the reservation tribe. The current language permits the initiation of redesignation procedures by a tribal resolution as one commentor suggested. Detailed procedures are inappropriate because of the divergent situations that might call for a redesignation.

15. Section 36.22(c) has been revised to simply provide that redesignations will be made in accordance with the Administrative Procedure Act (5 U.S.C. 553) rather than spelling out a requirement for an NPRM and a public comment period. These are generally provided for in the Administrative Procedure Act but the revised language would allow for the utilization of any exceptions permitted under that act if it were appropriate.

16. Section 36.23(a) has been revised to replace the phrase "any Indians, and the non-Indian wife and dependent members of the household of any such persons" by referring to persons described in § 36.12 of 42 CFR, which describes persons eligible for services at IHS facilities. This change, along with deletion of a definition of "Indian" for purposes of contract health services, will achieve consistency between §§ 36.23(a) and 36.12 and simplify the regulations governing IHS services. The change indicates that § 36.23(a) imposes eligibility requirements for contract health services in addition to, rather than independent of, § 36.12.

The change in § 36.23(a) to refer to persons described in § 36.12 is made recognizing that the Department plans to issue a separate notice of proposed rulemaking to amend § 36.12 with respect to the non-Indian husband of an eligible Indian and the non-Indian dependent members of an eligible Indian's household. Section 36.12, as did proposed § 36.23(a), includes the non-Indian wife, but not the non-Indian husband, of an eligible Indian. Several comments were received objecting to exclusion of non-Indian husbands in proposed § 36.23(a) on the ground that their exclusion constituted discrimination based upon sex. Non-Indian dependent members of an eligible Indian's household are presently served by the IHS, although § 36.12, adopted in 1956, has not been updated to include them. These issues will be dealt with in the notice of proposed rulemaking to amend § 36.12.

17. Section 36.23(a) has also been amended to make persons described in § 36.12 eligible for contract health services when they reside within a contract health service delivery area but do not reside on a reservation and are either members of or maintain close economic and social ties with the tribe or tribes located on the reservation or for which the nearby reservation was established.

A number of commentors pointed out that the proposed rule would exclude many Indians residing near a reservation within a contract health service delivery area who were not native to the area and members of the local tribe, but who had been receiving services from IHS and were members of the local Indian community. Several comments suggested that contract health services should be provided to Indians regardless of where they reside. Other comments spoke in favor of the original membership requirement. The above revision reflects the resources available to IHS, the recognition of the part the tribe plays in the relationship between the Federal Government and the Indian community, and a viable position between those who recommended retention of the tribal membership requirement and those who wanted neither tribal membership nor geographical criteria.

18. The term "on or near a reservation" has been deleted from § 36.23(b). It was redundant and confusing since a student or transient who was eligible for services "at the place of their permanent residence" would have had to reside "on or near a reservation,"

19. Section 36.23(b)(2)(ii) has been renumbered as § 36.23(c) and revised so that the language dealing with the period of eligibility when an individual leaves the contract health service delivery area more closely conforms to equivalent language in § 36.23(b)(1) dealing with a similar period covering students who no longer meet the special conditions of eligibility for students. The words "* * * or until alternate health care resources are available and accessible, whichever occurs earlier" are deleted because this is provided for by action of § 36.23(f) which was formerly § 36.23(c)(ii).

20. As a result of a number of comments, a new section, § 36.23(d), has been added which provides for the continued eligibility of Indian children after they are placed in foster care outside a contract health service delivery area when conditions involving previous eligibility and an order by a court of competent jurisdiction have been met. As was pointed out in the comments, this potential loss of eligibility placed undue and unnecessary burdens on Indian foster children and overly restricted the viable choices available to social service agencies and the courts in dealing with very difficult situations.

21. Section 36.23(c)(i) has been renumbered as § 36.23(e) and revised to omit the words "and access to other arrangements for obtaining the necessary care." This change is intended to make clear that priorities for contract health services will be determined on the basis of relative medical need. The accessibility of alternate resources is not solely a matter for consideration in establishing priorities when there are insufficient resources but rather is a factor of general applicability.

Former § 36.23(c)(ii) has been renumbered as § 36.23(f) and titled "alternate resources."

22. Renumbered § 36.23(f) has also been revised by adding to the end the words "* * * or would be available and accessible upon application of the individual to the alternate resource." This was done to clarify that failure to apply for alternate resources that are accessible and available does not mean that the resources are not accessible or available.

23. *Former* § 36.23(d), Evidence of tribal membership, has been deleted as no longer necessary in light of the change in § 36.23(a) referring to persons described in § 36.12.

24. Section 36.24, Authorization for contract health services, prompted a large number of comments and suggestions, some of which indicated a lack of clarity on the part of the proposed rule. This section has been extensively revised. As revised, the section provides that no payment will be made for medical care and services delivered by non-Service providers or in non-Service facilities unless a purchase order has been issued by the appropriate IHS ordering official after that official has been notified as spelled out in this section. This revision required the addition of a definition of "appropriate ordering official", designated as § 36.21(b) (see item 4 above). These changes address the expressed concern that nonmedical personnel might authorize medical treatment. A definition of "emergency" was added as § 36.21(f) to aid in the administration of this section (see item 5 above).

The notification requirements have been clarified and include a provision allowing, for good cause, a waiver of prior notice in nonemergency cases. In response to a comment, the notification requirements were revised to provide that an individual or an agency acting on behalf of the Indian may give the necessary notice.

A suggestion that all requirements for prior authorization are unreasonable and can result in burdensome requirements was not accepted due to the need to manage IHS resources and assure that only eligible individuals receive care under the IHS program. It was suggested that instead of prior authorization and notice IHS should issue Indians I.D. cards to indicate to providers the individual's eligibility, and a written description of the benefit package of health care services covered. This suggestion was not adopted because, in the absence of a congressional appropriation to fund such a benefit package, I.D. cards would have no purpose.

Many suggestions for greater detail were rejected as dealing primarily with interpretative and administrative matters and, therefore, more appropriate for inclusion in later manual issuances. For example, it was suggested that a standard form be developed so that individuals will know what must be disclosed to become eligible for contract health services. Guidelines will have to be developed which inform both IHS staff and applicants what information is appropriate to establish eligibility.

25. Comments on § 36.25, Reconsideration and Appeals, were made that 10 days was insufficient time to prepare and submit a request for reconsideration. The section has been changed to allow 30 days for submitting a request for reconsideration.

The procedures were revised to provide that in cases where the applicant submits additional supporting information not previously submitted, the applicant may obtain a reconsideration by the Service Unit Director who had made the original denial. Otherwise, the applicant may appeal directly to the Area or Program Director. This procedure was adopted to allow the Service Unit Director to make a determination based on all available information. It seems inappropriate to appeal to a higher echelon when the original denial was based on what might turn out to be incomplete information.

26. Section 36.25(c) was added to the regulation. It provides for a final appeal to the Director of the Indian Health Service. The decision of the Director will constitute the final administrative action by IHS. This additional level of appeal was added to provide a common point for appeals which should help assure greater uniformity in determining eligibility. It also adds an additional measure of protection to an applicant's potential right to service.

Several comments were received that suggested that the final appeals should be made to the tribe and that any other approach is an infringement on the ability of the tribes to govern themselves. This suggestion was not adopted because, in our view, current law would not permit such an approach. Another comment was received which suggested that the appeals process would be enhanced if there was a provision for appeal to another agency. This suggestion was not accepted because the addition of the Director of the Indian Health Service as the last level of administrative appeal of a denial of contract health services is considered adequate administrative protection of an applicant's rights.

B. DISCUSSION OF GENERAL COMMENTS

A number of comments were received that dealt with relevant issues but of a general nature. A discussion of these follows:

(1) A number of commentors stated that they were opposed to the entire concept of the "on or near policy." The reasons were varied but included the charges that the proposed regulations: violate the Snyder Act which provides for services for Indians throughout the United States; illegally limit eligibility of Indians by establishing contract health service delivery areas; violate the intent of Congress as expressed in the Indian Health Care Improvement Act (Pub. L. 94-437); are an illegal attempt to limit the Federal obligation to provide health services to Indians; and, by restricting participation of otherwise eligible Indian persons solely on the basis of residence, are thereby discriminatory and contrary to the original intent of the Federal Government.

There is no question as to the fact that IHS has authorizing legislation (Snyder Act, etc.) to provide contract health services to "Indians throughout the United States." However, in appropriating funds, Congress has provided funds for services to federally recognized Indians who live on or near Federal Indian reservations with certain exceptions, such as where funds have been specifically earmarked for urban Indian projects or particular tribal groups.

(2) Several respondents opposed the definition of contract health service delivery areas since county jurisdictional boundaries do not necessarily have any historical significance or meaning to Indians or their reservations. Section 36.22(b) permits tribal and other governing bodies of affected reservations to request appropriate redesignation of their contract health service delivery area. This provision is consistent with Indian self-determination and was favorably commented on by several tribal representatives.

(3) Several respondents requested implementation of the proposed regulations be postponed for various periods, ranging from a few months to indefinitely. Requests were made to provide Indian people more time to respond to the proposed regulations.

The proposed regulations, which were under development for more than two years, have received extensive public exposure and discussion through at least five national meetings and numerous communications between interested parties specifically to discuss developing regulations. Additionally, 60 days were allowed for comment after publication of the NPRM. Therefore, it is not deemed necessary to postpone publication of final rules.

(4) Objections were raised to the Indian Health Service program being a residual resource on the basis that such a position is illegal; is contrary to intent of the Snyder Act; and that it discriminates against the poor who are forced to use state and other available services. It was recommended that IHS should be the primary source of health services for Indians.

The position that resources of the Indian Health Service are residual to other health care delivery systems or health care payment mechanisms available and accessible to the Indian is neither illegal nor does it violate IHS authority. This position does not adversely discriminate agaist the poor since it maximizes the resources available for health care for all eligible Indians.

The Indian has a dual relationship to Federal, State and local governments stemming from his rights as a citizen and his rights as a member of a federally recognized Indian tribe. Indians and other native Americans are entitled under the Fifth and Fourteenth Amendments to the Constitution of the United States and under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000-d et seq.) to equal access to State, local and federally assisted programs available to other eligible members of the general population. Services available from the Indian Health Service cannot be considered as an alternative resource which could preclude the eligibility of Indians or other Native Americans for services under other programs or benefits or under contracts with health care providers or insurance carriers.

The required use of alternate resources does not jeopardize the Indians' unique relationship with the Federal Government, but merely maximises the health care services that can be provided with limited resources. Though an Indian may be eligible for an alternate resource, if it is not available and accessible to him, this otherwise eligible Indian will not be denied contract health services.

(5) Questions were raised regarding methods of carrying out IHS's responsibilities under the regulations (e.g., who is the local authorizing official: how will local policy be publicized?).

These and similar questions and issues concerning administrative procedures and program implementation are appropriate for Headquarters, Area and Service Unit issuances and policy statements. Policy will be posted and published locally and otherwise disseminated to assure the highest possible awareness among potentially eligible Indians.

(6) The National Indian Health Board (NIHB) took issue with the statement in the NPRM that the NIHB was unsuccessful in obtaining consensus among tribal groups. The NIHB considered this as reflecting a lack of understanding as to the NIHB's function (see 41 FR 46793, October 22, 1976). The statement in the proposed regulations may have been misleading. The NIHB commented that it is only a dissemination point for information for Board members and therefore it did not comment on the proposed regulations. It further stated that it was successful in its mission to disseminate information on the proposed regulations to its members.

(7) Some respondents reported that the proposed definition of "reservation" would guarantee IHS services to Indians located in places where IHS has not been funded by Congress to provide services. Section 36.22(a)(4) establishes contract health service delivery areas only with respect to reservations "within the funded scope of the Indian health program." This is applicable even under the revised definition of "reservation" contained in the final rule.

(8) Several legal aid groups took issue with limitation of services to members of federally recognized tribes, since the Snyder Act, as IHS's authorizing legislation, does not specifically contain this limitation. These commenters maintain that any Federal, State, or otherwise recognized group that is culturally identified as Indian comes within the Snyder Act authority for services from the IHS. It was not the purpose of the Snyder Act to extend benefits to Indians not federally recognized, but rather to authorize appropriations for Bureau of Indian Affairs' programs serving federally recognized Indians.

(9) A number of comments were made that the probability of an affected Indian person having access to the Federal Register is small and therefore the Federal Register is an extremely poor vehicle through which to reach Indians with a proposed regulation. It was suggested that these proposed regulations be published once a week for 3 consecutive weeks in a newspaper of general circulation within the affected localities. This suggestion was not adopted in light of the great effort which had been made to inform and to receive comments from the Indian community. Copies of the notice of proposed rulemaking were widely distributed to tribal governments and other interested groups for the purpose of explaining the proposed rules and seeking their input. Additionally, articles on these proposed regulations appeared in virtually every Indian newspaper in the country. Sufficient opportunity to respond to the NPRM has been provided to the Indian community.

C. Discussion of Miscellaneous Recommendations

The Secretary does not agree that the proposed rules would be improved as suggested by some commenters and has rejected the following suggestions.

1. A question was raised as to the meaning of "close economic and social ties" in reference to the tribal membership requirement appearing in § 36.22(a)(2) of the NPRM. It was suggested that this regulation contain additional material explaining these terms. As was discussed above, the strict tribal membership requirement has been eliminated. There is still, however, a valid question as to the meaning of this phrase since it remains as element in the eligibility criteria. The phrase is from the Supreme Court language in *Morton* v. *Ruiz*, 94 S.Ct. 1055, 415 U.S. 199 (1974). However, the Court did not define these terms for us. It is acknowledged that IHS will have to provide guidance to enable the appropriate IHS official to determine when the "close economic and social ties" criteria has been met but this is more appropriately left to administrative guidelines.

2. It was suggested that the terms "residing" and "resides" be defined. In general usage, a person "resides" where he or she lives and makes his or her home. In practice, these concepts can be very involved. Determinations will be made on generally applicable legal principles with the described appeals process as a protector of their proper application. Inclusion of definitions would, in our opinion, neither clarify nor simplify the application of this criteria.

(3) Several commenters suggested that a U.S. citizenship requirement should be added to the eligibility criteria for contract health services. This suggestion was rejected because the requirements that an applicant for contract health services be of Indian descent and maintain close economic and social ties with the nearby tribe are considered sufficient criteria to assure that the available resources will be used for the health of the Indian communities within the funded scope of the program.

(4) It was pointed out that the proposed regulations did not address the problem of which contract health service delivery area or service unit will be responsible for or will be charged for the cost of contract health services. We do not consider this an appropriate topic for regulations since it is an administrative function.

(5) It was recommended that the State of Arizona be declared as "Traditional Indian Territory." The basis for this recommendation seems to have been the concern that many Indians currently eligible would not be eligible because they are not members of the nearby tribe even though virtually the entire State of Arizona is included in one contract health service delivery area or another. The change in the criteria dropping the strict tribal membership requirement should mitigate this problem. In addition, changes in the boundaries of contract health service delivery areas are possible under the regulations and this will permit any needed adjustments. The entire State was not designated a contract health service delivery area because this would have been a major departure from the situation proposed in the NPRM and there was not sufficient indication of tribal wishes.

(6) It was suggested that present service unit boundaries be utilized for designation of "near." The county option combined with the flexibility for redesignation was finally proposed and is being adopted as a result of a great deal of consideration of other possibilities.

(7) One commenter recommended that enrolled tribal members should be considered within the scope of the local service unit contract health service program if they return to their native community to receive health care. The funded scope of this program covers federally recognized Indians who reside on or near reservations. If a tribal member did not reestablish residency on or near a reservation, the tribal member would be beyond the funded scope of the program.

(8) It was recommended that household members should be considered eligible rather than restrict eligibility to dependents. This issue will be dealt with under proposed revision to § 36.12, as explained above.

(9) It was recommended that provision be made to continue coverage when people must move in order to be near specialized care. Coverage would

be maintained as long as the person's "residency" did not change, if they were in transient status, or for 180 days if they fall under § 36.23(b)(ii).

(10) The recommendation that the 180-day grace period for obtaining alternate resources be reduced to 90 days was not adopted. The 180-day period is considered more appropriate to assure proper health service coverage.

(11) The suggestions that separate definitions for "students" and "transients" be included was not accepted because they are considered adequately described in § 36.23(b) (1) and (2). The suggestion will be kept in mind if experience indicates a need that cannot be met by administrative guidelines.

(12) It was recommended that urban Indian groups near reservations be included in the eligible population. Urban Indians could be included if they reside in a contract health service delivery area and meet all other eligibility criteria. Urban Indians are not eligible as a class as this would go beyond the funded scope.

D. COMMENTS BEYOND SCOPE

Several comments were received that went beyond the scope of the notice. They include suggestions:

1. That IHS seek funding to provide health care coverage, possibly through a type of health insurance, to Indians throughout the United States.

2. That a pro rata share of funds from other programs (e.g., medicare and medicaid) equivalent to that spent on Indian clientele be withdrawn from those programs and committed to IHS.

3. That supplemental funds be obtained from Congress to provide health care to eligible students and that these funds not affect the present IHS contract medical care budget.

4. That students be notified that when they make application for higher education financial assistance, they need to obtain any student health care plan available at the particular education institution.

5. That tribes issue identification cards so IHS and its contract health providers could recognize eligible members.

6. That IHS retain administrative procedures currently in effect in the Portland area Indian Health Service.

NOTE.—The Department of Health, Education, and Welfare has determined that this document does not contain a major proposal requiring preparation of an inflationary impact statement under Executive Order 11821 and OMB Circular A-107.

Dated: April 12, 1978.

JULIUS B. RICHMOND,
Assistant Secretary for Health.

Approved: July 22, 1978.

HALE CHAMPION,
Acting Secretary.

Part 36 of title 42 is amended by revising subpart C as follows:

Subpart C—Contract Health Services

Sec.
36.21 Definitions.
36.22 Establishment of contract health service delivery areas.
36.23 Persons to whom contract health services will be provided.
36.24 Authorization for contract health services.
36.25 Reconsideration and appeals.

Subpart C—Contract Health Services

§ 36.21 Definitions.

As used in this subpart:

(a) "Alternate resources" means resources other than those of the Indian Health Service contract health services program, available and accessible to the individual, such as health care providers and institutions (including facilities operated by the Indian Health Service), health care payment sources, or other health care programs for the provision of health services (e.g., medicare or medicaid) for which the individual may be eligible.

(b) "Appropriate ordering official" means, unless otherwise specified by contract with the health care facility or provider, the ordering official for the contract health service delivery area in which the individual requesting contract health services or on whose behalf the services are requested, resides.

(c) "Area Director" means the Director of an Indian Health Service area designated for purposes of administration of Indian Health Service programs.

(d) "Contract health service delivery area" means the geographic area within which contract health services will be made available by the IHS to members of an identified Indian community who reside in the area, subject to the provisions of this subpart.

(e) "Contract health services" means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service.

(f) "Emergency" means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.

(g) "Indian tribe" means any Indian tribe, band, nation, group, Pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(h) "Program Director" means the Director of an Indian Health Service "program area" designated for the purposes of administration of Indian Health Service programs.

(i) "Reservation" means any federally recognized Indian tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), and Indian allotments.

(j) "Secretary" means the Secretary of Health, Education, and Welfare and any other officer or employee of the Department of Health, Education, and Welfare to whom the authority involved has been delegated.

(k) "Service" means the Indian Health Service.

(l) "Service Unit Director" means the Director of an Indian Health Service "Service unit area" designated for purposes of administration of Indian Health Service programs.

§ 36.22 Establishment of contract health service delivery areas.

(a) In accord with the congressional intention that funds appropriated for the general support of the health program of the Indian Health Service be used to provide health services for Indians who live on or near Indian reservations, contract health service delivery areas are established as set out below:

(1) The State of Alaska;

(2) The State of Nevada;

(3) The State of Oklahoma;

(4) Chippewa, Mackinac, Luce, Alger, Schoolcraft, Delta, and Marquette Counties in the State of Michigan;

(5) Clark, Eau Claire, Jackson, LaCrosse, Monroe, Vernon, Crawford, Shawano, Marathon, Wood, Juneau, Adams, Columbia, and Sauk Counties in the State of Wisconsin and Houston County in the State of Minnesota.

(6) With respect to all other reservations within the funded scope of the Indian health program, the contract health services delivery area shall consist of a county which includes all or part of a reservation, and any county or counties which have a common boundary with the reservation.

(b) The Secretary may, from time to time, redesignate areas or communities within the United States as appropriate for inclusion or exclusion from a contract health service delivery area after consultation with the tribal governing body or bodies of those reservations included within the contract health service delivery area. The Secretary will take the following criteria into consideration:

(1) The number of Indians residing in the area proposed to be so included or excluded;

(2) Whether the tribal governing body has determined that Indians residing in the area near the reservation

are socially and economically affiliated with the tribe;

(3) The geographic proximity to the reservation of the area whose inclusion or exclusion is being considered; and

(4) The level of funding which would be available for the provision of contract health services.

(c) Any redesignation under paragraph (b) of this section shall be made in accordance with the procedures of the Administrative Procedure Act (5 U.S.C. 553).

§ 36.23 Persons to whom contract health services will be provided.

(a) *In general.* To the extent that resources permit, and subject to the provisions of this subpart, contract health services will be made available as medically indicated, when necessary health services by an Indian Health Service facility are not reasonably accessible or available. Persons described in and in accordance with section 36.12 of this part if those persons:

(1) Reside within the United States and on a reservation located within a contract health service delivery area; or

(2) Do not reside on a reservation but reside within a contract health service delivery area, and: (i) Are members of the tribe or tribes located on that reservation or of the tribe or tribes for which the reservation was established, or (ii) maintain close economic and social ties with that tribe or tribes.

(b) *Students and transients.* Subject to the provisions of this subpart, contract health services will be made available to students and transients who would be eligible for contract health services at the place of their permanent residence within a contract health service delivery area, but are temporarily absent from their residence, as follows:

(1) Students—during their full-time attendance at programs of vocational, technical, or academic education, including normal school breaks, such as vacations, semester or other scheduled breaks occurring during their attendance, and for a period not to exceed 180 days after the completion of the course of study.

(2)(i) Transients (persons who are in travel or are temporarily employed, such as seasonal or migratory workers), during their absence.

(c) *Other persons outside the contract health service delivery area.* Persons who leave the contract health service delivery area in which they are eligible for contract health services and are neither students or transients will be eligible for contract health services for a period not to exceed 180 days from such departure.

(d) *Foster children.* Indian children who are placed in foster care outside a contract health service delivery area by order of a court of competent jurisdiction and who were eligible for contract health services at the time of the court order shall continue to be eligible for contract health services while in foster care.

(e) *Priorities for contract health services.* When funds are insufficient to provide the volume of contract health services indicated as needed by the population residing in a contract health service delivery area, priorities for service shall be determined on the basis of relative medical need.

(f) *Alternate resources.* Contract health services will not be authorized by the Indian Health Service when, and to the extent that, alternate resources for the provision of necessary medical services are available and accessible to the individual requesting the services or would be available and accessible upon application of the individual to the alternate resource.

§ 36.24 Authorization for contract health services.

(a) No payment will be made for medical care and services obtained from non-Service providers or in non-Service facilities unless the applicable requirements of paragraphs (b) and (c) below have been met and a purchase order for the care and services has been issued by the appropriate ordering official to the medical care provider.

(b) In nonemergency cases, a sick or disabled Indian, or an individual or agency acting on behalf of the Indian, or the medical care provider shall, prior to the provision of medical care and services, notify the appropriate ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility. The requirement of notice prior to providing medical care and services under this paragraph may be waived by the ordering official if:

(1) Such notice and information is provided within 72 hours after the beginning of treatment or admission to a health care facility; and

(2) The ordering official determines that giving of notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.

(c) In emergency cases, a sick or disabled Indian, or an individual or agency acting on behalf of the Indian, or the medical care provider shall, within 72 hours after the beginning of treatment for the condition or after admission to a health care facility notify the appropriate ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services. The 72-hour period may be extended if the ordering official determines that notification within the prescribed period was impracticable or that other good cause exists for the failure to comply.

§ 36.25 Reconsideration and appeals.

(a) Any person to whom contract health services are denied shall be notified of the denial in writing together with a statement of the reason for the denial. The notice shall advise the applicant for contract health services that within 30 days from the receipt of the notice the applicant:

(i) May obtain a reconsideration by the appropriate Service unit director of the original denial if the applicant submits additional supporting information not previously submitted or, (ii) if no additional information is submitted, may appeal the original denial by the Service unit director to the appropriate area or program director. A request for reconsideration or appeal shall be in writing and shall set forth the grounds supporting the request or appeal.

(b) If the original decision is affirmed on reconsideration, the applicant shall be so notified in writing and advised that an appeal may be taken to the area or program director within 30 days of receipt of the notice of the reconsidered decision. The appeal shall be in writing and shall set forth the grounds supporting the appeal.

(c) If the original or reconsidered decision is affirmed on appeal by the area or program director, the applicant shall be so notified in writing and advised that a further appeal may be taken to the Director, Indian Health Service, within 30 days of receipt of the notice. The appeal shall be in writing and shall set forth the grounds supporting the appeal. The decision of the Director, Indian Health Service, shall constitute final administrative action.

[FR Doc. 78-21331 Filed 8-3-78; 8:45 am]

Montana United Indian Association

Phone:
443-5350

846 Front Street
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M U I A

November 16, 1981

ADDRESS TO THE HOUSE APPROPRIATIONS COMMITTEE

MR. CHAIRMAN, MR. VICE-CHAIRMAN AND MEMBERS OF THE COMMITTEE: MONTANA UNITED INDIAN ASSOCIATION (MUIA) IS GRATEFUL FOR THIS OPPORTUNITY TO ADDRESS YOU THIS AFTERNOON:

THE MUIA IS HEREBY SUBMITTING A REVISED REQUEST FOR FUNDING TO MAINTAIN HEALTH SERVICES PROVISION TO THE URBAN INDIANS OF MONTANA. THE MUIA RECOGNIZES THAT THIS LEGISLATURE IS HEAVILY BURDENED WITH REQUESTS FROM VARIOUS SOURCES ATTEMPTING TO OFFSET THE WIDESPREAD HUMAN SERVICES BUDGET CUTS PROMULGATED BY THE DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET, DAVID STOCKMAN. HOWEVER, THE MUIA WISHES TO POINT OUT THAT THERE ARE SEVERAL REASONS THAT MAKE THE CLINIC FUNDING REQUEST NOT ONLY VALID, BUT ESSENTIAL:

1) IT HAS BEEN AMPLY DEMONSTRATED BY THE MUIA'S EXPERIENCE, THE CONGRESS OF THE UNITED STATES, THE MONTANA SUPREME COURT, BY TESTIMONY GIVEN AT THE BLOCK GRANT HEARINGS ON OCTOBER 28TH AND 29TH AND AT THE HEARINGS OF SUB-COMMITTEE #2 ON NOVEMBER 9TH, 10TH AND 11TH OF THIS YEAR THAT PROVISION OF HEALTH CARE SERVICES TO NATIVE AMERICANS IN MONTANA HAS NOT ACHIEVED PARITY WITH THE MAJORITY OF THE STATE'S POPULATION.

2) When urban Indians are allowed access to health care, the cost of that care is far beyond the means of the majority to pay due to the low incidence of employment and the resultant lack of insurance coverage by third party payors. The approximate one-way distances form the nearest reservation to each of the urban health centers is detailed below:

Great Falls to Rocky Boys' = 87 miles
Helena to Flathead = 173 miles
Missoula to Flathead = 61 miles

It is important to note that very few Montanas would drive 174, 346 or 122 miles in the summer to receive Primary Health Care, even if they could afford the gasoline, to say nothing of making the same trip in the winter.

Equally important is the fact that appointments have to be made for the service delivery which many times involve planning weeks ahead. In addition, if urban Indians had the money for the gasoline to travel those distances, they could pay for local non-Indian primary care.

3) The Indian Health Service (IHS) has two pertinent funding regulations which are difficult to interpret due to the number of significant exceptions possible and the variability with which the seven reservations in the state treat each regulation, to wit:

a) The so-called "On or Near" policy basically states that Indian people residing on or near a reservation are entitled to IHS contract care. The operative clauses of this policy state that eligibility for contract care on a specific reservation depends, in part, upon an otherwise eligible

INDIVIDUAL'S PLACE OF RESIDENCE. IF AN ENROLLED MEMBER OF A TRIBE OTHERWISE ELIGIBLE TO RECEIVE CONTRACT CARE RESIDES IN A COUNTY ADJOINING AN INDIAN RESERVATION OR IN A COUNTY INTO WHICH THE BOUNDARY OF AN INDIAN RESERVATION PROTRUDES, THAT INDIVIDUAL MAY RECEIVE CONTRACT CARE, EVEN IF HE OR SHE DOESN'T RESIDE UPON THE RESERVATION PROPER.

THE NUMBER OF INDIAN PEOPLE QUALIFYING FOR "NEAR" RESIDENCY IS SO MINIMAL THAT THEY ARE NOT COUNTED IN MUIA'S URBAN POPULATION DATA BECAUSE IN FACT, THESE PEOPLE ARE, UNDER THE RULES, RESERVATION RESIDENTS.

B) THE "ONE HUNDRED-EIGHTY DAY" RULE STATES THAT IF AN INDIVIDUAL WHO IS OTHERWISE ELIGIBLE FOR CONTRACT CARE SERVICES HAS LIVED OFF (NOT "NEAR") THE RESERVATION FOR MORE THAN 180 DAYS, THAT PERSON MAY BE DENIED CONTRACT CARE UNLESS HE OR SHE RE-ESTABLISHES RESIDENCY PRIOR TO PROVISION OF CARE.

BOTH OF THE ABOVE REGULATIONS ARE SUBJECT TO INTERPRETATION BY THE TRIBE PROVIDING THE HEALTH SERVICE. FOR EXAMPLE, SOME TRIBES ALLOW ENROLLED TRIBAL MEMBERS LIVING OFF-RESERVATION (BEYOND THE LIMIT PROSCRIBED BY THE ON OR NEAR POLICY) TO ENJOY CONTRACT CARE SERVICES IF THEY ARE WORKING FOR THE TRIBE IN A CAPACITY THAT NECESSITATES LIVING IN A PLACE BEYOND THE ON OR NEAR POLICY'S PURVIEW. SECONDLY, MOST RESERVATIONS WILL PROVIDE PRIMARY CARE OR FIRST AID AS NECESSARY FOR EMERGENCY CASES AND WILL PROVIDE REFERRAL TO HEALTH CARE PROVIDERS AND FACILITIES OUTSIDE THE RESERVATION, BUT IN THESE CASES WILL NOT PAY FOR THOSE SERVICES NOR REIMBURSE EITHER THE VICTIM OR THE PROVIDER WHO RENDERED THE SERVICE.

4) The cost of health care provision nationwide has ballooned in excess of 19% in the last fiscal year, in Montana, this cost has risen by 11% during the same period. The urban Indian health programs that are administered by the MUIA have operated efficiently and effectively (confirmed by a nationally recognized management consultant firm) on a Congressional appropriation that has not changed for two fiscal years, namely an average of $217,073.17 for each of 41 urban Indian health projects across the United States. A measure of the effectiveness of MUIA's programs can be seen in the fact that we produced a carryover surplus in Fiscal 1980 which was applied to the past fiscal year's program needs. Due to a change in contracting procedures for Fiscal 1981, carry-overs now revert to the U.S. Treasury if not utilized or encumbered during that contract year.

5) The stark reality of the federal human services budget cuts is that there are more holes in the "safety net" than there is "net." The safety net concept will ultimately devolve upon Montana's 56 counties who will be footing the bill for sharp increases in the payment for acute episodic and emergency room care that will inevitably occur if the urban Indian health programs are not funded. In addition to assuming financial responsibility for the drastic cuts in other services, Montana's counties will be hard pressed to pay for emergent urban Indian health care because the urban Indian population will not seek preventive health from non-Indian clinics due to the historical humiliation, deprivation and discrimination suffered at the hands of many medical providers. The law of the land states that this should not happen;

HOWEVER, IT IS WELL KNOWN THAT FIRMLY ROOTED ATTITUDES AND PREJUDICES CANNOT BE LEGISLATED OUT OF EXISTENCE.

6) THE MONTANA SUPREME COURT, INTERPRETING THE LAW OF OUR LAND, POINTEDLY DEMANDED LAST THURSDAY (NOVEMBER 12, 1981) "A GREATER INSULATION OF INDIAN VALUES FROM WHITE INFLUENCES AND AUTHORITY..." AND THE COURT SAID "THE ACT (INDIAN CHILD WELFARE ACT OF 1978) WAS PASSED BY CONGRESS IN RESPONSE TO A SIGNIFICANT THREAT TO THE INTEGRITY OF INDIAN CULTURES IN THIS COUNTRY." THE SUPREME COURT ALSO STATED, "INDIAN PEOPLE, *whether residing on a reservation or not*, ARE IMMERSED IN AN ENVIRONMENT WHICH IS IN MOST RESPECTS ANTITHETICAL TO THEIR TRADITIONS." (EMPHASIS ADDED.) IN ADDITION, THE COURT NOTED THAT "...CULTURAL DIVERSITY AMONG INDIAN TRIBES IS PROFOUND BUT NOT FULLY APPRECIATED OR PROTECTED IN WHITE SOCIETY, BUT THE MONTANA CONSTITUTION RECOGNIZES THE NEED TO PRESERVE THE UNIQUE CULTURAL HERITAGE OF INDIANS." FINALLY, THE COURT DECLARED, "IN APPLYING OUR STATE LAW...WE ARE COGNIZANT OF OUR RESPONSIBILITY TO PROMOTE AND PROTECT THE UNIQUE INDIAN CULTURES OF OUR STATE FOR ALL FUTURE GENERATIONS OF MONTANANS."

IT MUST BE NOTED THAT ALL FOUR MEMBERS OF MONTANA'S CONGRESSIONAL DELEGATION FULLY SUPPORT THE MUIA'S HEALTH PROGRAMS AND HAVE SENT US LETTERS STATING THEIR POSITION ON THIS ISSUE. MUIA REPRESENTATIVES HAVE MET WITH EACH DELEGATE PERSONALLY REGARDING THE NECESSITY FOR CONTINUING OPERATION OF THE CLINICS. THE DELEGATION WAS HIGHLY VISIBLE IN ITS SUPPORT OF INCLUSION OF THE URBAN INDIAN HEALTH PROGRAMS IN THE INTERIOR BILL WHICH RECENTLY EMERGED FROM THE SENATE/HOUSE CONFERENCE COMMITTEE.

7) AS CAN BE CLEARLY SEEN BY THE ATTACHED TESTIMONY AND

budgets prepared at the invitation of Sub-committee #2, the MUIA has realistically trimmed the amounts necessary to operate and staff the clinics for Fiscal Year 1982. However, in the interest of presenting a request to a Legislature which finds itself severely limited by Federal Block Grants, the MUIA proposes three model funding budgets (attached) two of which reflect service delivery only; i.e., no administration, office materials and supplies, rent or other direct cost. The rationale behind this approach eminates from limited encouragement from private foundations and other charitable institutions who have indicated an interest in continuing the clinics but, like the state, cannot support the entire cost of maintaining them. Since the MUIA brought the issue before Sub-committee #2, cash and pledges totaling nearly $35,000.00 have been received.

LCOHOL, DRUG ABUSE AND MENTAL HEALTH GRANT →

In summary, you have before you a complete packet delineating the history of the Montana United Indian Association, the health services currently provided by the MUIA's clinic alliances, the funding proposal made to the State Department of Health, three distinct budget proposals, a health services fact sheet, letters of support from consumers and providers of medical care, letters from the Montana Congressional Delegation, materials prepared for the Appropriations Sub-committee, copies of newspaper articles, a transcript of pertinent testimony from the Sub-committee and a transcript of an interview aired on KTVG Newsline 12. The deliberations and recommendations of your committee will have a significant impact on the health status of not only the more than 16,000 urban Indian people in the state, but on the non-Indian population as well.

The Montana United Indian Association wishes to thank the Chairman, Vice-Chairman and Members of the Appropriations Committee for this opportunity to testify in the interest of the continuing provision of quality health care to Montana's urban Indian people.

QUA-QUI
CORPORATION MISSOULA INDIAN CENTER
Phone: (406) 329-3806
508 Toole Avenue ◇ Missoula, Montana 59801

November 16, 1981

RECEIVED
NOV 17 1981
MONTANA UNITED
INDIAN ASSOCIATION

Representative Ed Smith
Montana State Legislature
Capitol Building
Helena, Montana 59601

Dear Representative Smith,

I am writing in response to an article published in the Missoulian last week, November 12, 1981. It seems you mentioned that some of your Indian friends told you they are still receiving annual check-ups and major medical care from reservations.

Recently I became very ill, while residing in Missoula, and was put in the hospital immediately. In telephoning my tribe and explaining the emergency of my situation and the need for assistance, the contract officer responded by saying they would have to deny me any assistance because I wasn't living on the reservation. Unfortunatly in view of my emergency my Dr. didn't feel it would be wise for me to travel 500 miles to receive major medical services from my home reservation. The closest reservation hospital from Missoula, (45 miles away) also told me I could not get help from them because I was not a member of their tribe.

Contrary to your "friends" beliefs and consequently yours, not all Urban Indians qualify for services on reservations. In fact, hardly any of my Indian friends living in Missoula, qualify for any services on any reservation.

I hope this will clear up some misinterpretations concerning this matter.

Very sincerely

Harold Hamilton

Harold Hamilton

cc..Mr. Ben Bushyhead, Executive Director
Montana United Indian Association

(26)
RECEIVED
NOV 17 1981
MONTANA UNITED
INDIAN ASSOCIATION

November 16, 1981

Representative Ed Smith
Montana State Legislature
Capital Building
Helena, Montana 59601

Dear Representative Smith,

The recent article in the Missoulian dated November 12, 1981 has prompted me to write this letter.

A few months ago I was visiting my home reservation in Browning. During that time I became extremely ill and had to be transported by ambulence to a subcontracted unit of the Blackfeet tribe in Kalispell. Since then, I have been notified that my statis as an Urban Indian would make me inelligible for payment of services even though I became ill while visiting my home reservation.

Therefore, your beliefs that Urban Indians receive health care on reservations is unfounded. I know I am but one of numourous Indian people choosing to reside in an urban setting who has been refused health services from any reservation.

Please take this letter into consideration next time you generalize about all Urban Indians receiving annual checkups and major medical care whenever needed.

Sincerely,

Susan Tatsey

Susan Tatsey

cc. Mr. Ben Bushyhead, Executive Director
Montana United Indian Association

[illegible]

Mr. BAUCUS. Mr. President, I have [illegible] the concerns of Indian people who are not only from my State but from other States with significant Indian populations. What I am hearing is evidence Indians are indeed among the truly needy. Indians fall at the bottom of every social and economic indicator. They have the shortest life expectancy; they have the highest suicide rate; their poverty is 300 percent of the national average; they have the lowest per capita income; they have the highest unemployment rates; they have the lowest level of education, they have the poorest housing; and they have the worst health conditions and health care. It is little wonder there is an acute need for health care in urban areas.

How did this problem come about? In 1952, the Government policy of relocating reservation Indians to urban areas caused about one third of American Indians to move to cities. As a consequence of that policy it is estimated that about one-half of all American Indians live in urban areas. These estimates were made in 1976 and given the present economic conditions in rural areas, the percentage could be even higher.

Indians were not received in the cities with health care waiting for them, and currently the Indian Health Service of the Department of Health and Human Services will not provide direct health care to urban Indians. Individuals cannot afford to go to a reservation health center in most instances, and because people assume the Federal Government provides for its Indian wards, there are few urban health care delivery systems which have served Indian people. Where there are free health care systems, Indians are denied their services. It has also been found that there has been gross discrimination against Indians in tax-supported institutions. In other words, urban area facilities simply assume Indians have been provided for, and some discriminate against Indian people for reasons too lengthy and complex to comment upon here.

As a result of this situation, Indian and urban community leaders attempted to establish part-time volunteer community clinics. While those experiments were noteworthy and noble, they found that the health needs of urban Indians were larger than anticipated, due to the numbers of people to be served and due to the frequency and kinds of ailments to be treated. Thus they found they simply could not go further without outside funding.

As a result of this situation, we enacted the Indian Health Care Improvement Act, which was designed to bring Indian health to an acceptable level. Funding for programs under the act did not begin until fiscal year 1978, and now that the programs has gotten off the ground for funding urban Indian health programs, it is in great danger of death at an early age.

Our American Indian Policy Review Commission looked at these problems in a great deal of detail, and it developed the expertise to tell Congress what is needed to address some of the problems I mentioned earlier. On the issue before us the Commission recommended:

> Congress appropriate sufficient funds for the continuation of present Indian centers in urban areas which assist Indians in obtaining medical and other social services; and should encourage, with funds and guidance, the establishment of additional such centers in all urban areas where Indians live.

That is some of the background to the problem, but what is the current problem?

Of the 50 percent of all American Indians who live in cities, over 60 percent of that number are children of school age or younger. In other words, 33 percent of all American Indians are urban children. They, along with other urban Indians, have an unusual incidence of special medical problems. Some of the more recent studies of Indian health problems show that the No. 1 ailment among Indians is otitis media, an ear infection which is related to poverty and which can cause deafness. Reports show this ailment to be quite high in children, with 43.6 percent of the children having it being under the age of 5. If those little children are untreated they will have hearing problems which will cause them to do poorly in school, leaving more people in the vicious cycle of poverty. The No. 2 disease is strep throat, a highly infectious disease. It only makes public health sense to make certain there are facilities which can check the spread of this disease. The next highest ailment consists of intestinal infectious diseases, and we know these can cause a great deal of pain and even death. I will not go through the full list, which is available to you in government reports, but the fourth highest ailment is impetigo, a staphylococcal skin disease, the fifth is pneumonia, and the sixth is influenza. These are all serious ailments and many of them are very highly contagious. However you can see they are ones which can be treated easily and effectively in a clinic setting. If they are caught early through checkup programs and the encouragement of parents and others to come in, the community is protected and, more importantly, Indian people can obtain the medical care they deserve.

That is the background. We owe a dut, to the Indian peoples who were sent t our cities, we owe a duty to the cities t assist them in providing services, and th nature of the ailments treated requir public attention for the sake of th community at large. This program is on for the truly needy. It is fundamenta and it is in line with the history of th special relationship of the Federal Gov ernment to Indians. It is also a ste toward a better future. As one of my In dian constituents put it, "I have a visio of a day when being Indian and poor i America is not dangerous to you health."

Mr. President, it is, then, with grea concern that I note the action of t Senate Interior appropriations to total eliminate funding for the urban India health program.

The House, however, has seen fit fund the urban Indian health progra And it recommended $9.78 million f fiscal year 1982. When the Interior me ure goes to conference, I want to strong urge my colleagues to adopt the Hou figures for this very important heal care program.

Id.

Id.

American Indian Policy Review Commission Final Report, p. 388.

Report on Indian Health, supra, p. 140.

Id.

Final Report, supra, p. 366.

Id. [illegible]

PAT WILLIAMS
MONTANA
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CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

COMMITTEES:
EDUCATION AND LABOR
ELEMENTARY, SECONDARY AND VOCATIONAL EDUCATION
LABOR STANDARDS
HUMAN RESOURCES
INTERIOR
PUBLIC LANDS AND NATIONAL PARKS
ENERGY AND ENVIRONMENT

September 28, 1981

Mr. Ben Bushyhead
Executive Director
Montana United Indian Association
846 Front Street
Helena, Montana 59601

Dear Ben:

I just wanted to let you know that I've written to the conferees meeting on the Interior Appropriations Bill for FY 82 in support of the $9.7 million for Title V of the Indian Health Care Improvement Act.

Best regards,

Sincerely,

Pat

Pat Williams

Enclosure

RECEIVED
OCT 1 1981
MONTANA UNITED
[illegible]

THIS STATIONERY PRINTED ON PAPER MADE WITH RECYCLED FIBERS

PAT WILLIAMS
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CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

COMMITTEES:
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ELEMENTARY, SECONDARY AND VOCATIONAL EDUCATION
LABOR STANDARDS
HUMAN RESOURCES
INTERIOR
PUBLIC LANDS AND NATIONAL PARKS
ENERGY AND ENVIRONMENT

September 15, 1981

The Honorable Sidney R. Yates
Chairman
Subcommittee on Interior
Committee on Appropriations
B308 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Yates:

As you prepare to go to Conference regarding the FY'82 Interior Appropriations Bill, I urge you to insist on the House version regarding Title V of the Indian Health Care Improvement Act - dealing with Urban Indian Health.

There are currently more than 240,000 Indian people living in urban areas--many of them forced to urban centers because of the lack of employment on the reservations. With the severe impact of the budget cuts for Indian programs on the reservations, we can expect to see more Indian people moving to urban centers to seek employment. Whereas the $9.7 million as contained within the House Interior Appropriations Bill is not nearly enough to meet the health care needs of our urban Indian population, it will allow the work and success of the program to date to continue.

Monies spent in the Urban Indian Health Care Centers has been one of the best uses of federal monies evident. For every dollar of Indian Health Service funding to Urban Indian Health Centers, projects have been able to match funds from other sources. The health of urban Indians has improved and per-patient costs are well below the national norm.

My thanks for your help.

Best regards,

Sincerely,

Pat Williams

PAT WILLIAMS

WILLIAM S. COHEN, MAINE, CHAIRMAN
BARRY GOLDWATER, ARIZONA JOHN MELCHER, MONTANA
MARK ANDREWS, NORTH DAKOTA DANIEL K. INOUYE, HAWAII
SLADE GORTON, WASHINGTON DENNIS DeCONCINI, ARIZONA
TIMOTHY C. WOODCOCK, STAFF DIRECTOR
PETER S. TAYLOR, GENERAL COUNSEL

United States Senate
SELECT COMMITTEE ON INDIAN AFFAIRS
WASHINGTON, D.C. 20510

July 31, 1981

Ben Bushyhead
Executive Director
Montana United Indian Association
846 Front Street
Helena, Montana 59601

Dear Ben:

Thank you for your recent letter regarding the budgetary problems facing urban Indian health programs. As you may know, the House of Representatives has passed the Interior Appropriations bill which includes $9.79 million for urban health programs. Although the Senate Interior Approrpriations Subcommittee has not provided any funds for Indian urban health care, the Senate bill has not yet been presented to the full Senate.

Although I am not a member of the Senate Appropriations Committee and therefore will not be a conferee on this bill, I know that urban Indian health programs has provided vital health care to many people, and I will do what I can to preserve these worthwhile programs.

Best regards.

Sincerely,

John Melcher

John Melcher
Ranking Minority Member

RON MARLENEE
MONTANA

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Congreſs of the United States
House of Representatives
Washington, D.C. 20515

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(406) [illegible]

[illegible] FIRST AVENUE, NORTH
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(406) [illegible]
TOLL FREE
[illegible]

July 27, 1981

Ben Bushyhead, Executive Director
Montana United Indian Association
846 Front Street
Helena, Montana 59601

Dear Ben:

Thank you for your letter regarding funding for Title V of Public Law 94-437, the Indian Health Care Improvement Act. I appreciate knowing of your concerns on funding for urban and rural Indian Health Care Programs.

As you may recall, I wrote to Congressman Yates of the Interior Appropriations Subcommittee and requested that funding be restored for Title V Indian Health Care Programs. The $9.79 million was then adopted by the Full Committee on Interior Appropriations.

I will not be a member of the House-Senate Conference on Interior Appropriations, and I would suggest that you contact Senator Melcher and Senator Baucus on this matter. The House of Representatives did vote to retain $9.79 million for Urban Indian Health Care Programs, but the Senate has not yet voted on the Interior Appropriations bill.

Ben, I appreciate your letting me know of your concerns on this matter, and I hope you will always feel free to call on me regarding any issue of interest to you.

Sincerely,

Ron

RECEIVED
JUL 30 1981
MONTANA UNITED
INDIAN ASSOCIATION

8—The Montana Standard, Butte, Thursday, November 12, 1981

Indian health clinics denied money

By JAMES DeWOLF
Standard State Bureau

HELENA — By a one-vote margin, a legislative Appropriations subcommittee has scalped a group of urban Indian health service providers.

But, the Montana United Indian Association says it can't give up yet and probably will resubmit its funding request to the entire Legislature.

The 6-5 decision came after Sen. Ed Smith, R-Dagmar, said he had checked with Indian friends who told him that claims about urban Indians not qualifying for medical care on all reservations are untrue.

Smith said some of his friends have left their reservations for decades and still are returning for annual checkups and major medical care. "I think we've been misled a little bit," said Smith.

Association officials said the rule for Indian Health Service care is that it can't be given to anyone who has lived away from a reservation for more than 180 days. They said money for Montana's seven reservation health programs is drying up and strict enforcement of eligibility rules is becoming more common.

THE GROUP is seeking $345,000 for each of two years to continue the operation of Indian health clinics in Great Falls, Helena and Missoula, along with outreach transportation programs in Anaconda, Butte and Miles City. The Indian group says it could operate the clinics for $285,000 a year.

Backers say the clinics are necessary because urban Indians often are poor and routinely are denied the health services available to other Montanans.

Up until now the health programs have been federally supported. But, federal cuts in funding may run as high as 100 percent and the association says if that happens, Indian centers and the clinics may fold.

Legislators said there simply wasn't enough money available in a federal block grant for preventative health care to continue funding state and county health programs while providing for the urban Indian clinics.

A tenative motion urging county health departments to make sure Indians are not left out of county health programs failed to get even to the voting stage. Some legislators argued that funding the clinics would create an excuse to continue racism.

SEN. FRED Van Valkenburg, D-Missoula, chided the Indian group for being unrealistic in opposing his earlier suggestion that the state could fund one of the clinics for $80,000 a year.

"You missed the boat in Washington D.C.!" said Van Valkenburg, before making a surprise motion to fund just one clinic.

The proposal was voted down. Afterwards, Ben Bushyhead, executive director of the association, said there is a discrimination problem that federal laws have failed to remedy. He said urban Indian clinics were told to expect block grant funding earmarked for them, but that it was never approved at the federal level.

"If (this committee) had given us $30,000, it would have been OK," he said.

8—Missoulian, Thursday, November 12, 1981

Panel turns down Indian-clinic funds

Missoulian State Bureau

HELENA — By a one-vote margin a legislative Appropriations subcommittee has turned down a funding request from a group of urban Indian health-service providers.

But the Montana United Indian Association says it can't give up yet and will probably resubmit its funding request to the entire Legislature.

The 6-5 decision came after Sen. Ed Smith, R-Dagmar, said he had checked with Indian friends who told him that claims that urban Indians can't qualify for medical care on all reservations are untrue. Smith said some of his friends have lived away from reservations for decades and are still returning for annual checkups and major medical care.

Association officials said Indian Health Service care is not supposed to be given to anyone who has lived away from a reservation for more than 180 days. They said money for Montana's seven reservation health programs is drying up as strict enforcement of eligibility rules is becoming more common.

The group seeks $345,000 for each of two years to continue the operation of Indian health clinics in Great Falls, Helena and Missoula, along with outreach transportation programs in Anaconda, Butte and Miles City. It says it could operate just the clinics for $285,000 a year.

Legislators said there simply wasn't enough money available in a federal block grant for preventative health care to continue funding state and county health programs while providing for the urban Indian clinics

Sen. Fred Van Valkenburg, D-Missoula, chided the the association for being unrealistic in opposing his earlier suggestion that the state could fund one of the clinics for $80,000 a year

That proposal was voted down.

After that vote, Ben Bushyhead, executive director of the group, said there is a discrimination problem that federal laws have failed to remedy. He said urban Indian clinics were told to expect block grant funding earmarked for them but it was never approved at the federal level

"If you (this committee) had given us $30,000 it would have been OK," he said

Indian health service request is scalped

4-C Thursday, Nov. 12, 1981 The Billings Gazette

By JAMES DeWOLF
Gazette State Bureau

HELENA — A legislative appropriations subcommittee scalped by a one-vote margin a request from a group of urban Indian health service providers.

But the Montana United Indian Association says it can't give up yet and will probably resubmit its funding request to the entire Legislature.

The 6-5 decision came after Sen. Ed Smith, R-Dagmar, said he had checked with Indian friends who said claims that urban Indians can't qualify for medical care on all reservations are false.

Smith said some of his friends have left their reservations for decades and are still returning for annual checkups and major medical care. "I think we've been mislead a little bit," he said.

MUIA officials said Indian Health Service rules say it can't be given to anyone who has lived away from a reservation for more than 180 days. They said money for Montana's seven reservation health programs is drying up and strict enforcement of eligibility rules is becoming more common.

The MUIA is seeking $345,000 for each of two years to continue the operation of Indian health clinics in Great Falls, Helena and Missoula along with out-reach transportation programs in Anaconda, Butte and Miles City. The MUIA says it could operate just the clinics for $285,000 a year.

Backers say the clinics are necessary because urban Indians are often poor and are routinely denied the health services available to other Montanans.

Up until now the health programs have been federally supported. But federal cuts in funding may run as high as 100 percent and the MUIA says if that happens Indian centers, as well as the clinics, may fold.

Legislators said there simply wasn't enough money available in a federal block grant for preventative health care to continue funding state and county health programs while providing for the urban Indian clinics.

A tentative motion urging county health departments to make sure Indians are not left out of county health programs failed to even get to the voting stage and some legislators argued that funding the clinics would create an excuse to continue racism.

Sen. Fred Van Valkenburg, D-Missoula, chided the MUIA for being unrealistic in opposing his earlier suggestion that the state could fund one of the clinics for $80,000 a year.

"You missed the boat in Washington D.C.," said Van Valkenburg before making a surprise motion to fund just one clinic.

The proposal was voted down and afterwards Ben Bushyhead, executive director of the MUIA, said there is a discrimination problem that federal laws have failed to remedy. He said urban Indian clinics were told to expect block grant funding earmarked for them but it was never approved at the federal level.

"If (this committee) had given us $30,000 it would have been OK," he said.

(34) p.

Thursday, November 12, 1981 Great Falls Tribune 1-C

Indian health clinic funding request denied

By CHARLES S. JOHNSON
Tribune Capitol Bureau

HELENA — By a 6-5 vote, a legislative budget committee rejected a scaled down request Wednesday to finance a health clinic for urban, non-reservation Indians.

The Indians also were told by one senator that they would be better off using existing health facilities designed to serve all people instead of establishing their own clinics.

Separate facilities serve only to encourage animosity and will not help Indians overcome discrimination, Sen. Thomas Keating, R-Billings, said.

The urban Indians originally had sought [illegible] in state money over the next two years for the state to pick up financing of health clinics in Great Falls, Helena and Missoula and some referral operations in other cities.

These clinics are financed primarily with federal money now, but the Montana United Indian Alliance found out only recently that the federal government is cutting off their money. The clinics currently receive no state money.

The Indians had pleaded with the committee earlier this week for money, but their full [illegible] request was never voted on by the committee.

At that time, legislators told the Indians that their request was for more than half of the total money granted to the state for all preventive health programs.

Sen. Fred Van Valkenburg, D-Missoula, told the Indians their original request was unrealistic in light of the budget cutbacks facing the state.

"You missed the boat in Washington, D.C.," he said.

Van Valkenburg then tried to appropriate $80,000 a year to pay for one clinic, which he said probably belonged in Great Falls, which has the most landless, non-reservation Indians who would be served.

His motion failed on a 6-5 vote.

Joining Van Valkenburg in support of the proposal were Reps. Francis Bardanouve, D-Harlem; Andrea Hemstad, R-Great Falls; and Sens. Bill Thomas, D-Great Falls, and Lawrence Stimatz, D-Butte.

Successfully opposing the attempt were Reps. Burt Hurwitz, R-White Sulphur Springs; Rex Manuel, D-Fairfield; Chris Stobie, R-Thompson Falls; and Sens. Ed Smith, R-Dagmar; Keating; and Jan Wolf, R-Missoula.

After losing their attempt, Mike Welsh, health director for the Indian group, said the organization would make another pitch before the full House Appropriations Committee next week.

He and other association officials said the group would be willing to accept any money from the state, even as little as $30,000, to try to keep the programs operating.

Their arguments on behalf of the programs fell on generally deaf ears.

Smith said he believed the Indian officials had tried to mislead the committee previously when they said most Indians who left their reservation for six months lost their right to free medical and dental care.

"Everyone I've talked to said they'd never been denied services" on reservations no matter how long they had been gone, Smith said.

Although policies vary, [illegible] said the six-month rule generally applies if the reservation received Indian Health Service money from the federal government.

Ben Busyhead, executive director of the Montana United Indian Association, said the reservations' first priority is to serve those Indians still living on the reservation.

Other legislators questioned why Indians couldn't obtain medical service from county health departments like other needy people.

At the previous hearing, association officials said Indians often have trouble obtaining adequate medical services from private physicians and government programs.

If Indians are being turned away from county health departments, they should file lawsuits because it constitutes illegal discrimination, said Bob Johnson, Lewis and Clark County health officer.

The committee considered inserting a provision stipulating the the preventive money distributed by the state was to serve all persons regardless of their race. But that motion was ultimately withdrawn as meaningless since the state constitution and law already ban such discrimination.

But Busyhead told reporters after the meeting that "you can't legislate discrimination out of practice."

Discrimination still exists despite enactment of the 1964 U.S. Civil Rights Act and other laws, he said.

Clinical Services Director Jennifer Topash (left) and registered nurse Yvonne Blackburn may work for half-pay at the Helena Indian Alliance clinic if the alliance fails in its bid for state financial help.

Urban Indians lose health sk

BY JAMES DEWOLF
IR State Bureau

By a one-vote margin a legislative appropriations subcommittee has snipped a group of urban Indian health service providers, including those in Helena.

But the Montana United Indian Association (MUIA) says it can't give up yet and will probably resubmit its funding request to the entire Legislature.

The 6-5 decision came after Sen. Ed Smith, R-Dagmar, said he had checked with Indian friends who told him that claims that urban Indians can't qualify for medical care on all reservations are untrue.

Smith said some of his friends have left their reservations for decades and are still returning for annual checkups and major medical care.

"I think we've been misled a little bit," said Smith.

MUIA officials said the official rule for Indian Health Service care is that it can't be given to anyone who has lived away from a reservation for more than 180 days. They said money for Montana's seven reservation health programs is drying up and strict enforcement of eligibility rules is becoming more common.

The MUIA is seeking $345,000 for each of two years to continue the operation of Indian health clinics in Great Falls, Helena and Missoula along with out-reach transportation programs in Anaconda, Butte and Miles City. The MUIA says it could operate just the clinics for $280,000 a year.

Backers say the clinics are necessary because urban Indians are often poor and are routinely denied the health services available to other Montanans.

Up until now the health programs have been federally supported. But federal cuts in funding may run as high as 100 percent and the MUIA says if that happens Indian centers, as well as the clinics, may fold.

Legislators said there simply wasn't enough money available in a federal block grant for preventative health care to continue funding state and county health programs while providing for the urban In-

But Helena's 'invisible' ones

By STEVE HINTZ
IR Staff Writer

They are in some ways an invisible people, Helena's landless Indians. The U.S. Census Bureau doesn't acknowledge the existence of many, and the state of Montana has been hardly aware of the half of its Native American population living off reservations, according to Ed Kennedy, director of the Helena Indian Alliance.

But the alliance tried at legislative hearings this week to convey an image of urban Indian needs. And even though an appropriations subcommittee Wednesday voted down 6 to 5 a request for health care funds, Kennedy sees the close vote as "a victory of sorts."

"We were able to get a fair hearing. We're going to regroup and approach the full House Appropriations and Senate Finance committees" during the session that begins Monday.

The alliance hopes to receive at least $45,000 in block grant money to keep its medical clinic in full operation in the face of federal budget cuts. The request is included in a larger plea for $345,000 from Indian groups in six Montana cities.

At issue in Helena is whether the desperately poor landless Indians can continue to receive health care in a clinic run by

Independent Record
SATURDAY
November 7, 1981
Helena, Montana
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Indian clinics will seek state money

By JAMES DeWOLF
IR State Bureau

A new and expensive burden will be dropped in the laps of state legislators Monday when operators of three non-reservation Indian health clinics make their case for first-time funding.

Spokesmen for the Montana United Indian Association say they have no choice but to ask for state money because they are facing an anticipated 100 percent reduction in federal funding.

The MUIA will present legislative testimony seeking $345,000 for each of two years. The money would pay for health clinics in Great Falls, Helena, and Missoula and transportation and referral programs in Anaconda, Butte and Miles City.

If the Legislature opted to fund only the clinics, the cost would be reduced to $285,000 annually and patients would be required to provide their own transportation from the outlying areas.

The urban health program is aimed at the more than 50 percent of Montana Indians who have left their reservations and no longer are eligible for tribal and Indian Health Service programs.

Urban Indians should be able to get medical services from doctors and programs that serve the rest of the population. But Ed Kennedy, director of the Helena Indian Alliance, said it doesn't work that way.

(More on CLINICS, page 12A)

Clinics

(Continued from page 1A)

Kennedy said most of the patients his clinic serves are poor and they have difficulty convincing regular physicans they can pay for the service, even when they are enrolled in welfare assistance programs.

"The first question always is, 'How are you going to pay for this?' " Kennedy said. "We had a case yesterday in which a mother took her child to a Helena clinic for treatment of an epileptic seizure. She is an approved welfare patient but she didn't have the paper with her and they wouldn't treat the child.

"After a couple of occurences like that our people won't go to a regular physician unless they are very sick or about to die."

Because of poor health care the MUIA says middle age in the Indian population begins in the 30s with only a small percentage reaching senior citizen status, which begins at age 45.

Administrator Mike Welsh said the clinics are moving toward self sufficiency in fund raising from foundations, churches, medical insurance reimbursements and local charities.

"We are asking for a hand up, not a hand-out, for two years until we can become self supporting," Welsh said. "It was always our plan to get away from the federal funding but these cuts just hit too fast."

The clinics hire doctors and nurses on a part-time basis to provide preventive care and minor medical treatment. The average cost per patient visit is $18 and Montana has more than 100,000 potential patients.

Welsh said the clinics often prevent serious medical complications. The prevention reduces the cost to other welfare programs that pay the major medical expenses of the poor, he said.

Funding for the urban Indian health programs has been criticized since January. Congress has extended the program for another two years but the president is expected to veto the appropriation.

Kennedy said promises that block grants would make up the lost federal funding have fallen flat in the past few weeks.

"This is a long shot," he said of the state request. "But we have to try it."

KTVG INTERVIEW AIRED ON FRIDAY, 11-13-81
@ 5:30 & 10:00 p.m.

"The Montana United Indian Association says it will resubmit its funding request to the entire legislature on Monday. The action follows their 6 to 5 narrow funding defeat by a legislative sub-committee. John Deering has more." "Following the 6 to 5 defeat by legislative sub-committee, Montana United Indian Association Executive-Director, Ben Bushyhead, said his association will resubmit its funding request on Monday.

The defeat came after Senator Ed Smith, a Republican from Dagmar, said he had checked with unnamed Indian friends who told him that Indians not living on reservations were indeed receiving medical attention on reservations.

But as Mike Welsh, the Health Director of MUIA says, the existing law does not require Indians to actively live within reservation boundaries. 'John, this is a very complex issue and I would simply respond that Senator Smith may have asked his friends who are not privy to the Indian Health Service regulations and may also be living on or near the reservation. "On or near" is a concept that says that Indian Health Service contract services may be given to those people who live in a county adjoining an Indian reservation or in a county into which the boundary of an Indian reservation protrudes'.

Welsh said another official rule for Indian Health Service care is that it can't be given to anyone who has lived away from a reservation for more than 180 days. The MUIA is seeking 345,000 for each of two years to continue the operation of Indian Health Clinics in Great Falls, Helena and Missoula along with outreach transportation programs in Anaconda, Butte and Miles City. From the Montana United Indian Association, John Deering reporting for Newsline 12."

Montana United Indian Association

Phone:
443-5350

846 Front Street
Helena, Montana
59601

MUIA

ADDRESS TO THE SENATE FINANCE AND CLAIMS COMMITTEE
NOVEMBER 19, 1981

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: MY NAME IS MICHAEL WELSH -- I AM THE HEALTH DIRECTOR OF THE MONTANA UNITED INDIAN ASSOCIATION, ALSO KNOWN AS THE "MUIA."

SOME OF YOU MAY REMEMBER ME AS THE SLIGHTLY WHIMSICAL, SLIGHTLY OVERWEIGHT FELLOW WHO PRESENTED THE CASE TO THE SUB-COMMITTEE FOR QUALITY HEALTH CARE PROVISION FOR THE MORE THAN 16,000 URBAN INDIANS RESIDING IN THE METROPOLITAN AREAS OF MONTANA.

I ATTENDED THE BLOCK GRANT HEARINGS HELD AT CARROLL COLLEGE ON OCTOBER 29TH AND 30TH WHERE MUIA REPRESENTATIVES WERE TOLD POLITELY BUT FIRMLY THAT OUR HEALTH PROGRAMS WERE PROFESSIONALLY RUN AND FILLED A GAP IN THE HEALTH CARE DELIVERY SYSTEM, BUT DUE TO THE FACT THAT WE HADN'T APPLIED FOR MONIES UNDER THE APPROPRIATE BLOCK GRANT, WE WERE NOT ELIGIBLE TO RECEIVE FUNDING. WHEN WE POINTED OUT THAT WE HAD JUST RECEIVED NOTICE OF THE BLOCK GRANTS AND THEREFORE COULD NOT HAVE APPLIED, WE WERE TOLD THAT SINCE WE HADN'T BEEN FUNDED UNDER ANY OF THE SEVERAL CATEGORIES OF THE BLOCK GRANTS THE PREVIOUS YEAR, WE WEREN'T ELIGIBLE IN ANY CASE!

MUIA IS AN EQUAL OPPORTUNITY EMPLOYER

BILLINGS AMERICAN INDIAN COUNCIL
BILLINGS MONTANA
NORTH AMERICAN INDIAN ALLIANCE
BUTTE MONTANA
GREAT FALLS INDIAN EDUCATION CENTER
GREAT FALLS MONTANA
HELENA INDIAN ALLIANCE
HELENA MONTANA
MISSOULA QUA-QUI CORPORATION
MISSOULA MONTANA
HI-LINE INDIAN ALLIANCE
HAVRE MONTANA
NORTH AMERICAN INDIAN LEAGUE
DEER LODGE MONTANA
ANACONDA INDIAN ALLIANCE
ANACONDA MONTANA
NATIONAL ASSOCIATION OF BLACKFEET INDIANS

IT WAS THEN SUGGESTED WITH WRY HUMOR THAT WE APPLY TO THE STATE OF MONTANA FOR SOME PORTION OF OUR FISCAL YEAR 1982 FUNDING. THE REST IS HISTORY.

BEING POLITICALLY QUITE NAIVE, WE PACKED UP WHAT WE FELT WERE VERY IMPRESSIVE RECORDS OF OUR COST EFFECTIVENESS, PROGRAM EFFICIENCY AND SERVICE DELIVERY, CONTACTED VARIOUS LEGISLATORS AND SAT IN HOPEFULLY AT WHAT WE HAD BEEN TOLD WAS THE APPROPRIATE SUB-COMMITTEE. IN SUB-COMMITTEE NUMBER TWO WE HAD OUR FIRST INKLING THAT ALL WAS NOT WELL, BUT WE WERE ENCOURAGED BY THE CLOSENESS OF THE SIX TO FIVE NEGATIVE VOTE. WE REDOUBLED OUR EFFORTS WITH THE HELP OF A FEW POLITICAL SAVANTS AND A COUPLE OF SINCERELY CONCERNED COMMITTEE MEMBERS. THUS ARMED, WE PLUNGED AHEAD TO A RESOUNDING TWELVE TO FIVE DEFEAT IN THE EXECUTIVE COMMITTEE. WE BELIEVED THAT WE HAD ANSWERED ALL OF THE ISSUES THAT HAD ARISEN BEFORE, NAMELY: WHY OUR PROGRAMS DON'T DUPLICATE SERVICES; CONCURRENCE FROM THE TOP HEALTH OFFICIALS THAT OUR PROGRAMS ARE NEEDED (AT LEAST UNTIL ATTITUDES CHANGED BETWEEN INDIANS AND THE REST OF MONTANA'S CITIZENS); WE THOUGHT WE HAD FINALLY LAID TO REST THE SPECTER OF THE "ON OR NEAR" POLICY AND THE NOW INFAMOUS 180 DAY RULE; WE FELT THAT WE HAD QUOTED THE MONTANA SUPREME COURT WITH MAXIMUM EFFECT SINCE THAT AUGUST BODY DECLARED THAT SEPARATE FACILITIES ARE NOT DISCRIMINATORY DUE TO THE UNIQUE CULTURAL AND SOCIAL STRUCTURE OF MONTANA'S INDIAN PEOPLE. WE WERE CONVINCED THAT WE HAD FORCEFULLY INDICATED THAT MONTANA'S COUNTIES (WHICH APPEAR TO BE FACING MASSIVE WELFARE COSTS) WOULD BE FURTHER FINANCIALLY STRAPPED BY HAVING TO SHOULDER THE COST OF THE INEVITABLE EMERGENCY ROOM CARE THAT WILL QUICKLY RESULT FROM LACK OF

PRIMARY HEALTH CARE PROVISION TO URBAN INDIAN PEOPLE. WELL, WE BELIEVED, THOUGHT, FELT AND WERE CONVINCED -- WRONG!

TUESDAY NIGHT, AS BEN BUSHYHEAD AND I ROAMED THE HALLS OF THIS AMAZING SEAT OF WESTERN DEMOCRACY, WE DISCUSSED THE SAFETY NET, "THE COLLECTIVE RESPONSIBILITY TO HELP" AND A COMMENT THAT A DISTRESSED LEGISLATOR HAD MADE MOMENTS BEFORE TO THE EFFECT THAT WE WERE ASKING TOO MUCH OF THE LEGISLATURE -- ONE HUNDRED THOUSAND DOLLARS SIMPLY WASN'T REALISTIC, ESPECIALLY IN VIEW OF THE OTHER ISSUES THAT HAD TO BE ADDRESSED. BEN AND I AGREED WITH EACH OTHER THAT 100,000 DOLLARS IS A LOT OF MONEY: WE ALSO CAME TO THE CONCLUSION THAT MILLIONS ARE BEING SPENT ON INANIMATE, COMMERCIAL AND MATERIAL CONCERNS. IT MADE US WONDER IF THIS STATE CAN AFFORD TO IGNORE ITS INTRINSIC HUMAN RESPONSIBILITY TO ITS FIRST CITIZENS. UP TO THIS POINT, URBAN INDIANS HAVE MADE NO SIGNIFICANT FINANCIAL DEMANDS OF THE STATE OF MONTANA. YET, INDIAN PEOPLE WERE RELOCATED TO URBAN AREAS AS EARLY AS 1952 AGAINST THEIR WILL; THE FACT THAT THESE PERSONS NOW DESIRE TO AVAIL THEMSELVES OF THE OPPORTUNITY TO BETTER THEIR LIVING CONDITIONS IN A CITY OR TOWN OF THEIR CHOICE IS USED AGAINST THEM. SOME MONTANANS ARE PRONE TO SAYING, "WHY DON'T THE INDIANS ASSIMILATE THEMSELVES INTO OUR SOCIETY -- YOU WOULD THINK BY NOW THEY WOULD BE USED TO THE WAY WE LIVE. WHY DON'T THEY PULL THEMSELVES UP BY THEIR BOOTSTRAPS?" MY RESPONSE TO THAT WAY OF THINKING IS SIMPLY THAT IT IS AWFUL DARN HARD TO PULL YOURSELF UP BY YOUR BOOTSTRAPS WHEN SOMEONE TAKES AWAY YOUR BOOTS AND THEN YOUR STRAPS!

IT OCCURED TO ME THAT BILLIONS OF DOLLARS ARE SPENT ANNUALLY

TO PROMOTE PRIVATE BUSINESS AND THAT THE OVERWHELMING MAJORITY OF THESE FLEDGLING OPERATIONS END IN TOTAL FAILURE IN LESS THAN A YEAR. IT FURTHER CAME TO ME THAT THE STATE COULD EASILY LOOK UPON $99,057.00 AS A RELATIVELY SMALL INVESTMENT IN A PROVEN, FINANCIALLY ACCOUNTABLE ENTERPRISE THAT IS FAR BEYOND THE "FIRST YEAR JINX," WILL MATERIALLY IMPROVE THE HEALTH STATUS OF A GROSSLY NEGLECTED POPULATION, HAS ALREADY IMPROVED THE EDUCATIONAL POSSIBILITIES AND THEREFORE THE WORK OPPORTUNITIES OF A STEADILY INCREASING NUMBER OF PEOPLE -- (AN INTERESTING SIDE NOTE IS THAT IF A YOUNG PERSON HAS OTITIS MEDIA -- A DISEASE THAT IS PANDEMIC AMONG INDIANS -- THE CONDITION PROGRESSES VERY RAPIDLY UNTIL PARTIAL OR TOTAL LOSS OF HEARING ENSUES; IF STUDENTS CANNOT HEAR, THEY DO NOT LEARN, IF THEY DO NOT LEARN, THEY CANNOT COMPETE IN THE WORKPLACE; IF THEY CANNOT COMPETE IN THE WORKPLACE, THEY LOSE ALL FEELING OF SELF-WORTH AND END UP BEING SUPPORTED BY THE STATE).

THE MOST INTERESTING FINANCIAL ASPECT OF THIS PROPOSITION IS THAT THE MUIA, A NON-PROFIT, NOT-FOR-PROFIT CORPORATION, POURS NEARLY TWO MILLION DOLLARS INTO THE STATE'S ECONOMY EACH YEAR -- BEN AND I AGREED THAT TWO MILLION DOLLARS EVERY YEAR IS ALSO A LOT OF MONEY. IF THE CLINIC PROGRAMS FOLD, THE MUIA'S FINANCIAL STABILITY WILL BECOME LESS VIABLE AND THE LOSS TO THE STATE IN UNEMPLOYMENT COMPENSATION AND LOCAL REVENUE WILL BE SUBSTANTIALLY MORE THAN THE $198,114.00 BEING REQUESTED FOR ONLY TWO YEARS.

WEDNESDAY MORNING, AS I FOUGHT A LOSING BATTLE WITH INSOMNIA AND TANGLED SHEETS WHILE WRESTLING WITH NIGHTMARISH THOUGHTS RELATING TO OUR APPARENT FAILURE TO IMPRESS UPON THE HOUSE THE URGENCY AND IMPORTANCE OF OUR PROGRAMS, MY WIFE TOLD ME TO STOP

TOSSING AND TO PUT MY THOUGHTS ON PAPER. I ASKED HER, "WHAT MORE CAN I TELL THEM -- THEY HAVE ALL THE FACTS." SHE SAID SLEEPILY, "TELL THEM A STORY -- ABOUT YOUNG INDIANS AND OLD INDIANS; EVERYONE LOVES YOUNG AND OLD INDIANS." THE TRUTH OF HER WORDS FINALLY STRUCK ME. I REFLECTED ON THIS UNTIL I REACHED THE OFFICE.

HERE THEN, IS THE STORY: IF THE MUIA DOESN'T OBTAIN FUNDING TO CONTINUE ITS CLINIC OPERATIONS, YOUNG INDIANS WILL NOT DEVELOP INTO OLD INDIANS. THE WISDOM OF THE ELDERS THAT HAS BEEN THE HALLMARK OF INDIAN TEACHINGS AND TRADITIONS WILL NEVER COME ABOUT. INDIAN YOUTH WILL BE IMPAIRED, PHYSICALLY AND MENTALLY, AND THE "OLD" (MEDIAN DEATH AGE -- 55 YEARS) WILL DIE BEFORE THEY CAN IMPART TRADITIONAL CULTURAL AND RELIGIOUS HERITAGE TO THE MORE RADICAL MEMBERS OF THE COMMUNITY. IT IS IMPORTANT FOR YOU AS LEGISLATORS TO RECOGNIZE THE EXTREME IMPORTANCE OF A TEMPORARY MONETARY VICTORY VIS A VIS A LONG-TERM INVESTMENT IN THE DESTINY OF A PEOPLE. A WISE MAN ONCE SAID, "TO THE VICTOR GOES THE RESPONSIBILITY."

I WILL BELABOR OUR POSITION NO LONGER BEFORE THIS COMMITTEE -- YOU HAVE THE COLLECTIVE WISDOM, THE LEGISLATIVE POWER AND THE MEANS (IF YOU SEEK THEM) TO ENSURE A BRILLIANT FUTURE FOR THE URBAN INDIAN CITIZENS OF MONTANA.

THANK YOU.

(REPRESENTATIVES FROM THE MUIA ARE PRESENT AND WILL REMAIN TO ANSWER ANY QUESTIONS YOU MAY HAVE ON THIS ISSUE.)

Montana United Indian Association

Phone
443-5350

848 Front Street
Helena, Montana
59601

M U I A

October 2, 1981

Ms. Linda Richardson
Professional Staff Member
Senate Interior Appropriations Committee
1208 Dirksen Office Building
Washington, D.C. 20510

Dear Ms. Richardson:

Pursuant to our conversation on October 1, 1981, pertaining to an equitable, objective system for determining which Urban Indian Health Projects should be funded, the following information is submitted:

1. In a rural state such as Montana, the value of transportation and referral projects cannot be overemphasized. The urban areas of Montana include only two Standard Metropolitan Statistical Areas (SMSAs), Billings and Great Falls. Missoula has the next significant population with 33,388 inhabitants. Since Montana is the fourth largest state in land area and only forty-fourth in population among the United States, it is readily apparent that transportation and referral services to provide access to health care is a primary consideration. A valid indication of the distances to be traveled in Montana is: to transport a client or patient from Miles City to Fort Peck is analogous to traveling from Washington, D.C. to Princeton, New Jersey to obtain medical services. Public Law 94-437, Title V, Section 501, Indian Health Care Improvement Act, reads "The purpose of this title is to encourage the establishment of programs in urban areas to make health services more accessible to the urban Indian population."

2. While it is true that some urban projects are not as effective as they could be, it is equally true that the Montana United Indian Association (MUIA) has taken firm steps to eliminate those projects. The MUIA Board of Directors, recognizing their responsibility to ensure program compliance and cost effectiveness, cancelled contractual agreements with the Hi-Line Indian Alliance in Havre due to non-compliance with contractual requirements. The alliance was operating a Phase II Health project. Since that time, efforts have been made to attempt coordination with the Rocky Boys' and Fort Belknap Reservations

ensuring Havre's Indian residents access to health services on those reservations.

3. In August of this year, the MUIA proposed to the American Indian Health Care Association (AIHCA) a set of objective criteria that can be used to evaluate the cost effectiveness and service delivery of Urban Indian Health Programs. The AIHCA adopted the criteria and subsequently recommended to the Indian Health Service (IHS) that project funding be based upon a three month evaluation of existing programs utilizing the adopted criteria to determine which projects would be funded fully in Fiscal Year 1982. The MUIA strongly endorses this equitable determination of program effectiveness and measure of service delivery. The time period of the Continuing Resolution, in addition to FY 1981 efforts, could be utilized to evaluate existing programs.

4. The criteria submitted for your consideration are as follows:

I. Clinic Alliances (Phase III and IV Projects)

  A. Need for Services (A ratio)

    1. Population utilizing clinic health services divided by number of direct clinic health services delivered from October 1, 1980 through November 1, 1981.

  B. Cost Effectiveness

    1. Per patient encounter dollar cost (dollars expended divided by number of patients) from October 1, 1980 through November 1, 1981.

    2. Percentage of funding utilized for administrative purposes (total administrative health budget divided by the total health contract number).

II. Non-Clinic Alliances (Phase II Projects)

  A. Need for Services

    1. Population utilizing transportation and referral services divided by total Native American population in the service area.

    2. Distance from Health Project Urban area to nearest IHS funded Health Facility in miles.

B. Cost Effectiveness

1. Per client encounter dollar cost (number of total health contract dollars divided by number of clients served from October 1, 1980 through November 1, 1981).

2. Percentage of funding utilized for administrative purposes (total administrative Health Budget divided by the total health contract amount).

5. Utilizing the foregoing criteria, each project will be competing against other projects within its own category (Phases II, III, and IV) for funding. In regard to the present status of clinics and non-clinics phase designation, the status indicators have not been updated since 1976. Therefore, the phase status of record does not accurately reflect the actual work being done by the centers. In addition, the criteria will establish what relative level of funding the projects would be allocated by rank-ordering the highest scoring projects within each category and not funding the remaining projects. The MUIA stands ready to aid in the application of this criteria; we recommend that an evaluation committee be convened composed of IHS representatives and a representative from each of the affected sub-contractors to evaluate Urban Indian Health Projects. These binding recommendations would then be forwarded to the Headquarters of the Indian Health Service for final funding determination.

Because the American Indian people have been asked to absorb four percent of the Administration's total budgets cuts, many of which will directly affect the reservations, the influx of Indian people to urban areas will be phenomenal.

Please feel free to utilize my office for any further information or assistance you may require.

Sincerely,

Mike Welsh
Health Director

MW/sw
Enclosure: Guide to Final Report of American Indian Policy Review Commission Exerpt
cc: Debbie BrokenRope
Judy Chapman
Dick Hargesheimer
Wes Halsey
Cathy Johnson
Senator McClure
Ramona Ornelas
Susan Witte
Representative Yates
All MUIA Alliance Directors and Health Directors

A GUIDE TO THE FINAL REPORT OF THE AMERICAN INDIAN POLICY REVIEW COMMISSION

Prepared by:

Native American Rights Fund
Boulder, Colorado

American Indian Law Center
University of New Mexico
Albuquerque, New Mexico

CHAPTER 9: OFF-RESERVATION INDIANS

The federal intention to provide services to off-reservation Indians was firmly established when Congress enacted the Snyder Act in 1921 providing appropriations for the benefit, care and assistance of Indians throughout the United States. More recently, Congress has reaffirmed its intention to provide services to off-reservation Indians in enacting the Indian Health Care Improvement Act, certain provisions of the Comprehensive Employment and Training Act, and programs under the Office of Native American Programs. In these pieces of legislation, the eligibility of urban Indian centers to receive funds and administer services is clearly stated.

The Commission report could have provided this background as the basis for claims of off-reservation Indians that they are entitled to federal services. However, the chapter is so poorly written and legally confusing that it serves to obfuscate the issue of off-reservation Indian entitlement. Instead, the chapter addresses a variety of mechanisms through which urban Indian centers might provide services to off-reservation tribal members. The two major alternatives presented would (1) provide funding directly to the urban Indian center, or (2) provide funding direct to tribal governments, whereupon tribal governments would allocate funds to urban Indian centers on the basis of population of their tribal members residing in the urban center service area. It is assumed that the last recommendation contained in the chapter speaks to the second alternative by recommending that the "Executive Branch should conduct a detailed examination of assistance programs and need areas to determine which would be most expeditiously administered by tribal governments."

Other recommendations request Congress to direct the Executive to deliver appropriate services through urban Indian centers. This recommendation should probably be in the form of a direct recommendation to the Executive, and would probably be more meaningful if what is meant by "appropriate services" were explained. The reader may assume that the recommendations relative to employment, education, housing and health are those "appropriate services" contained in the first recommendation, and if this assumption is true, then perhaps the first recommendation is unwarranted as being too general to be meaningfully implemented.

The second recommendation calls for Executive branch assurance of financial support for Indian centers in urban areas by turning over BIA Employment Assistance Offices and their contracting powers to urban centers; and removing Federal domestic assistance dollars from separate programs and targeting them to urban centers. The latter part of this recommendation is extremely unclear and appears to be administratively infeasible. That is, from whom would Federal domestic assistance dollars be removed? From the tribal government? Or does the recommendation address the splitting of Federal domestic assistance programs? Since there is presently no mechanism within the federal system to separate parts of programs and target them to specific groups, it is doubtful that this recommendation could be accomplished. Rather, if the intent of the recommendation is to make urban centers eligible for federal programs, the recommendation should call for the amendment of federal domestic assistance program legislation and regulations in such a manner as to specify the eligibility of urban Indian centers.

A third recommendation is also unclear. It recommends that the Department of the Interior should direct the BIA to give its contract powers, as a matter of policy, in all urban functions, now and in the future, particularly employment placement, vocational training, and its appropriate administrative support, to urban Indian centers. Because the BIA does not have contract powers to give, the recommendation would better accomplish its goal by recommending a broad reading of Section 4(c) of the Indian Self-Determination and Educational Assistance Act or amendment of the language contained in Section 4(c) to expressly include urban Indian centers as eligible for contracting Bureau programs under Public Law 93-638.

The recommendations addressing employment, housing, health and education represent constructive approaches to the problems of off-reservation Indians.

Indian Development & Educational Alliance, Inc.
504 Main Street - P. O. Box 726
Miles City, MT 59301
Phone: 232-6112

December 16, 1981

Senator John Melcher
United States Senate
Washington, D.C.

Dear Senator Melcher:

Indian Development And Educational Alliance, Inc. is concerned with the budget cuts made and future budget cuts. To reduce our present level of funding would greatly hinder health services for 1,000 off-reservation Indians living in Eastern Montana.
The last five years we have recieved around $22,000 per year to provide transportation services to IHS clinics, health counseling services, referal to various hospitals, etc., coordination between IHS and local health services, and provide Indian Nursing training for 12 female Indians on a yearly basis.
Enclosed you will find a copy of our five year activity report.
thank you for your concern for Native Americans living in Eastern Montana.

Sincerely,
Ernest C Bighorn
Ernest C Bighorn, Jr. Director

Indian Development & Educational Alliance, Inc.
504 Main Street - P. O. Box 726
Miles City, MT 59301
Phone: 232-6112

INDIAN DEVELOPMENT AND EDUCATIONAL ALLIANCE, INC.

FIVE YEAR NARRATIVE BRIEF REPORT

I. Indian Development and Educational Alliance, Inc., (IDEA) was incorporated on March 28, 1971 in the State of Montana to serve, represent, and or refer Native Americans and/or non-reservation Indian living in Southeastern Richland, Garfield, Treasure, Rosebud, Prairie, Dawson, Wibaux, Carter, Fallon, Powder River, McKone and Custer counties.

II. Indian Development and Educational Alliance, Inc., is organized to promote, protect, develop and seek out educational, career training, employment opportunities, scientific, literary, legal information and related cultural purposes or such other purposes for the improvement and welfare of the American Indians.

III. Indian Development and Educational Alliance, Inc., made 6,915 direct health, health-related, employment, educational, personal, social, family and legal contacts during the past 5 years, approximately 2,305 indirect contacts were made concerning coordination, with other health, education, employment, social, legal and other resources.

IV. Indian Development and Educational Alliance, Inc., with a staff of one part-time Director, one part-time bookkeeper, and two full-time counselors worked directly with 2,375 Indian clients during the past 5 years. Approximately another 2,877 family members were indirectly affected. The average age of our client was 28 years old. Ind most cases we worked with single-parent families.

V. Indian Development and Educatinal Alliance, Inc., made 7,028 direct health and health contacts during the last five years: 2064 direct contacts concerning personnal, social, family, legal, and other problems, 838 general counseling, 691 employment and training counseling and referrals, 549 direct contacts with clients enrolled in an educational program, 510 direct contacts with clients relating to alcoholism, 460 clients not enrolled in any school, 431 contacts with students enrolled in an Registered Nursing program, 322 contact with clients experiencing health problems, 235 contacts with clients who expressed health needs but no services, 162 referrals/transportation to local clinics, 90 requested assistance to pay medical bills, 89 requested help to identify themselves as being an Indian because they were adopted by non-Indians, [illegible] referrals/transportation to Indian Health Service Eye clinics and [illegible] reqested family planning services.

Indian Development and Educational Alliance, Inc., provided services to the following Indian tribes in Eastern Montana; (5,252) 1,432 Northern Cheyenne, 1,378 Fort Peck Sioux, 494 South Dalota Sioux, 487 Chippewa, [illegible]49 Fort Peck Assiniboine, 199 Blackfoot, 149 Gros Ventre, 145 Crow, 97 Arapaphoe, 108 non-Indians, 74 Shonshone, 54 Fort Belknap Assiniboine, 47 unknown, 49 Pawnee, 32 Choctaw, 108 Landless Indians, 32 Salish/Kootnai, 41 Tilinglit, 10 Southern Cheyenne, 13 Apache, and others. ($2.85) per client.

Indian Development & Educational Alliance, Inc.
504 Main Street - P. O. Box 726
Miles City, MT 59301
Phone: 232-6112

VI. Indian Development and Educational Alliance, Inc., coordinated post-secondary education programs with Fort Peck Assiniboine Sioux, Northern Cheyenne, Crow, Blackfoot, Cree/Chippewa and Fort Belknap Bureau of Indian Affairs Adult and Higher Education Offices. We have placed fifteen female Indian Nursing students at Miles Community College during the past five years. $8,500.00 was the average Bureau of Indian Affairs Grant. Total pre-nursing and regular nursing grants generated for the past five years totaled $212,500.00. The $212,500.00 is an average of five students per year times five years.

VII. Indian Development and Educational Alliance, Inc., made 150 employment placements with Montana Dakota Utilities, Mountain Bell, Montana State Highway Department, various construction companies, local business and farmers/ranchers. To our estimations 50% still are working or have changed employment. If there are 75 Indians still working with a minimum wage of $3.35, the employees would be making around $7,000.00 each per year or 75 still working times $7,000.00 per year would mean $525,000 on taxable in-come. Most of our Indian placements are single with three dependents therefore paying $250.00 Federal taxes per year, $23.76 for State taxes per year. Total times 75 Indians for five years, Federal $93,600.00, total $8,900.00 State. Most of the Indians placed were receiving some form of public assistance from counties, state or federal public assistance agencies.

VIII. Indian Development and Educational Alliance, Inc., is coordinating and cooperating with health, mental health, social services, legal, civil, and other resources to meet the unmet needs of Native Americans in Southeastern Montana. The program activities are of benefit to the community in many unseen ways. Indian Development and Educational Alliance, Inc., has developed an understanding of Federal Laws, rules and regulations and polities which affect Indian-federal relationships. Federal Indian Reservations in Montane are governered by elected tribal officals. Each elected body is different than each other therefore complicating resource coordination.

IX. Indian Development and Educational Alliance, Inc., are providing a service to Indian clients and to the social, economic, educational communities in South Eastern Montana.

Indian Development & Educational Alliance, Inc.
504 Main Street, P.O. Box [illegible]
Miles City, MT 59301
Phone: 232-6112

MONTHLY ACTIVITIES REPORT

Alliance INDIAN DEVELOPMENT & EDUCATIONAL ALLIANCE INC.
Date Prepared DECEMBER 14, 1981
Period Beginning OCTOBER 1981 Period Ending SEPTEMBER 30, 1982
Completed by STAFF
Directors Signature

Client Visits:

	Phone	Referral To	Transportation in town	Transportation out town	Home	Office	Tota
City-County Health	66	62	13	8		26	175
I.H.S.	232	113		28		57	430
Private Physician	75	105	41	6	2	20	249
Para Legal	73	49	1			19	142
Dental	27	20	6	10		7	70
Handicapped	9	13	4	3	2	3	34
Mental Health	78	26		14	3	14	135
Optometric	46	28				19	93
W.I.C.	14	26	1			13	54
Hypertension screening		4		1			5
Prescriptions	11	19	5	2	3		40
Family Planning	38	14	9		2	4	67
Welfare-Food Stamps	44	36	6			13	99
Elderly Nutrition	5	1				1	7
Health Social Services	141	114	8	2	51	174	490
Alcoholism	126	112	2	5	23	104	372
Non-Health							
Subsistence (food)	10	20				26	56
Employment	106	141	6	2		233	488
Education	104	119	12			37	272
Clothing	14	22				21	57
Housing	[illegible]	39				116	202
TOTALS							3,537

TOTAL UNDUPLICATED NUMBER OF CLIENTS SERVED THIS MONTH 1,100

Anaconda Indian Alliance
209 East Park
Debbie Cuny Health Co-ordinator

The Anaconda Indian Alliance is one of the smaller alliances which recieves its funding through the Montana United Indian Association (M.U.I.A.). It is located in the western part of the state with a population of approximately 11,000 residents in Deer Lodge County. The Alliance was designated by M.U.I.A. to service the tri-county areas of Deer Lodge, Powell, and Granite Counties.

A Needs Assessment Survey conducted in 1980 documents a total of 940 Native Americans residinf in the tri-county area. From this survey we were able to find out the most predominant problems in the areas of: Employment, Social Service, and Health Care, thus enabling us to update our services accordingly.

We assist with Health related problems by offering the following services to all Native Americans in our catchment area: Transportation, Outreach and Referral, Advocacy, Health Education, Hypertension, and Contracted Medical Services on an emergency basis, and some Pharmicudical Care. In 1981, the Anaconda Indian Alliance Health Program served an unduplicated total of 1691 health related encounters.

Since we are one of the smaller alliances, we are ineligible for clinical dollars, but because of careful budgeting practices we were able to allocate a limited amount of dollars to our Contracted Medical Services. With these dollars we were able to provide direly needed health care to Native Americans in our area.

The sole purpose of P.L. 94-437 is to bring the health of Native Americans to par to that of the rest of the nation. We at the Alliance feel that four years has not been a sufficient time to do such. It is well known that Native Americans tend to ignore health problems that may be ailing them and not ask for assistance from other Social Service Agencies. But, through a consistantly funded health program at the alliance, we are able to provide preventive health care on a more permanent basis and hopefully curb trivial health problems before they become crutial.

Following are some examples of Health Program experiences. Through co-ordinated efforts with the Mental Health Program at the Alliance a client with a terminal brain tumor is recieving regular Chemo Therapy treatments and his family referred to a group help service for families of terminally ill members. This past fiscal year the Health Program identified seven new hypertension victims resulting in medication control. Through our transportation service, we are able to transport clients to State or Reservation Health Care Agencies resulting in cost-effectiveness for our Health Program. Forty-three clients were able to recieve Optometric Care at minimal costs through the Ronan Eye Clinic trip provided eight times this past year. Fort Harrison Veteran's Hospital is also utilized to the fullest as many of our elderrly clients are Veteran's. Two of these clients transported this past year had a prognosis of inoperable cancer and were shipped to Salt Lake immediately to begin Cobalt treatment.

Had a Health Program geared toward the Cultual Needs of the Native Americans not been available; these and other seemingly minor health problems would go ignored thus untreated resulting in unmet health needs of Native Americans. It is hoped that all Statesmen will study these facts to the degree they deserve and act accordingly.

December 21, 1981

Good morning Mr. Chairman and Committee members.

My name is Carol Owens, I am the Health Director for the Native American Center in Great Falls, Montana. At the present time on file we have 2,020 registered Indian clients at our clinic. We have besides myself, a Registered nurse and a Medical Assistant on duty. We no longer have CETA support personnel to assist us with our clinic operation. Therefore, the three of us have found ourselves overlapping each other in our work, in order to meet the needs of our clients. This we don't mind, however, we are greatly concerned over the fact that there is a possibility of being defunded altogether or reduced of funds and possible cuts in our administration. Our present administative costs are 18% which is 2% below the 20% criteria for Title V monies. If our administrative costs are cut, our program will suffer even further as our present staff is spread dangerously thin with the average of 673 clients per staff member. We no longer have a CETA van driver to take clients to medical appointments. Who takes them? I do, because there is no one else and I am acutely aware that lack of transportation is one of the major problems facing our clients. Because of our limited budget we take clients to the Rocky Boy Health Clinic for medical, dental and optometric appointments on a weekly basis and pick up medications for clients. As you probably know the Rocky Boy clinic is over 100 miles away and I know that it would be very difficult for many of our clients to get there without our van. Would you like to see one of your loved ones hitch-hiking to a clinic 100 miles away because they lacked the access to local medical care? We have a client right now who stated that if we were not able to help provide her medications she would stop taking them. It would be sudden death for her as she suffers not only from servere congestive heart failure, but epilepsy. I would like to read her letter:

December 15, 1981

To Whom It May Concern:

Without the assistance I have been receiving from the Native American Center, I would not be able to exist.

I am presently taking 10 medications for my Congestive heart failure and my Epilepsy. They are Dilantin, Phenobarbital, Enduron, Apresoline, Lasix, Lanoxin, Isordil, Nitrobid, and Premarin Vaginal Cream. Because there was a time period when the Center did not have written authorization to provide services and the Van didn't make its trips to Rocky Boy, I had to purchase Enduron, Apresoline, Lanoxin, Isordil, and Nitrobid at a local drug store and it cost me almost $75.00. This is only half of the pills I am supposed to take everyday. On my husband's small retirement, we cannot afford the prescriptions plus the high doctors bills together each month.

My husband is a diabetic, his pills cost us about $10 a month and his diet has to be a little bit of everything. With grocery costs , we cannot afford my medical expenses on top of it and if it weren't for the girls at the Center and their insistance I would never have started this medical treatment anyway.

If this program is not continued I will be forced to stop all of my pills and then there will be no reason for me to see the doctor again.

I will just have Christmas with my children and try to enjoy it because I know it will be my last one.

Thanks for all the assistance I have received in the past. I really have appreciated it.

Sincerely yours,

Mrs. Lucille Bruno

This is approximately $150 per month for medications and does not include the cost of her specialists which she attempts to pay for. In the past we have been getting most of her medications from Rocky Boy and picking up what they did not have in stock, but Rocky Boy has given us a written memo stating they can no longer provide prescriptions to patients who do not physically present themselves to the pharmacy. (See attached memo) They also informed us verbally to send our patients in and their doctor on staff would check them and prescribe the necessary medications and once they followed this procedure, we could once again pick up the medications for them. This is not working as we have been sending clients down and just the other day, a client came in after she and her husband had been down there and was flatly told by the physician that her disease was beyond his capabilities and said he couldn't treat her. He told her to go back to Great Falls to see her own doctor. This is a vicious circle and who suffers, the client. If anything our funding should be increased, which then could alleviate critical situations that arise. I think we are very fortunate to be able to use the Rocky Boy's health clinic as the health staff up there has been very receptive to us, and if it wasn't for that facility our present budget could never have withstood the number of clients that need to be served with the budget we have had to work with.

These are just a few concerns we have had. I could go on and on about the adverse effects on clients if loss of funding were to happen, but I know the time here is limited. I would also like to mention that we did submit a formal proposal to the Malmstrom Air Force Base's Commanding Officer for health services in October 1980. Before, submission we had several meetings to discuss the possibility of health services becoming available at the base for our clients and the implications were very favorable as the base doctors said it would be a challenge to work with clients who had different diseases and were of different age groups. It would be a welcome change to be able to use their knowledge and skills on people who were not just young and healthy. We were told the proposal would go to the Strategic Air Command for consideration and hopefully acceptance. As of today we have had no response. We have recently sent a follow-up letter asking for some type of response.

I have copies of the proposal which I will leave for you. I would also like to mention that I am truly in favor of Urban Indian Clinics and I am not just speaking as an employee, but more as a bystander because I have had a first hand insight in the many positive things that have helped alleviate ignorance of the process of disease and of disease itself among the Indian people through our health program. I would like to go on record and say that I still firmly believe through fact and documentation, that our health clinic is a very credible program and deserves every opportunity to be considered for funding. It is very disenheartening to know we are one of the wealthiest nations in the world, yet when it comes to the federal budget, the Native Americans get a bare pitance of .4%.

In closing I would like to say, could the small pox infested blankets given to the Indians so long ago, be compared to disturbing events of today, such as defunding Indian Programs, could this be a form of subtle genocide?

Thank you,

Carol Owens

Carol Owens

Qua-Qui
Corporation MISSOULA INDIAN CENTER Phone: (406) 329-3805
608 Toole Avenue <> Missoula, Montana 59801

December 15, 1981

Senate Select Committee on Indian Affairs
Washington, DC 205[illegible]

Dear Committee Members:

Attached is a copy of the written testimony prepared by Ms. Sue Schield, Health Director, that I will be presenting before the Committee during the oversight hearing on the impact of fiscal year 1982 budget reductions on Indian Health Service funded and operated programs being held on December 21, 1981 at Billings, Montana.

I will be available to answer any questions that you might have and to provide you with additional information regarding our health program. I am looking forward to meeting each of you.

Very sincerely,

Susan Vassau Tall Bull

Susan Vassau Tall Bull
Health Outreach Worker

Attachment: 1

JUSTIFICATION

It is the purpose of this testimony to assist you in addressing the issue that there does exist an inalienable right for Urban Indians to receive adequate, decent health care.

This inalienable right was once recognized through the authorization and reauthorization of a Federal responsibility spelled out in a Public Law, PL-94-437 of the Indian Health Care Improvement Act. Five years ago, it was mandated that we should implement the Federal responsibility for the care and education of Indian people by improving the services and facilities of Indian Health Programs. We were finally given a green light to prove that the American Indians choosing to reside in the Urban settings were in dire need of health care. The prevalance of blatant, substandard health care, documented by factual needs assessments was proven and circumstances associated with Indian people not being able to utilize community health resources was clearly spelled out.

As the determination in knocking down the barriers preventing fair and equal health care persisted and as the credibility of Qua Qui Corporation's Health Program progressed, we were at last able to provide direct health services. These services have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature death of Native people. For example, we now see expecting mothers, who would otherwise not seek prenatal care until they are forced to return to the reservation to deliver, now receiving regular monthly prenatal check-ups. Otitis Media, the most prevalent illness among Indian children, often times causing deafness, is now being detected early. The preventative treatment now available has halted unnecessary suffering to many of our children. Diabetic patients, before utilizing the clinic would actually ignore their illness because of the inabilities to afford insulin. We have been able to instill trust in patients by linking them with their first family doctor and consequently curtailing unnecessary, expensive trips to the threatening atmosphere of hospital emergency rooms.

What was once seen as a necessary obligation of the Federal government, mandated by Congress, and backed up by treaty obligations to provide equal health care to Indians is now being ignored. This not only negates all of our accomplishments back five years to the beginning of having to prove the needs through assessments, it pushes us back thirty years when Indian people started relocating to the cities.

Unless recognition is given now to the cost effective, successful Urban Health Programs and proper allocations are distributed fairly, Indian people will once again be neglected and an unjust element of human suffering will all too blantantly prevail.

PROVEN COST EFFECTIVENESS

Preventative health care, provided at Qua Qui's Clinic has taken presidence over last minute emergency room visits which our patients needlessly over used. Emergency room costs are triple of that charged by our clinic physicians for office visits. Our contracted pharmacist has greatly attributed to the efforts of cost efficiency by using generic drugs whenever possible. Lab and X-ray expenses are contracted through low-cost facilities. Dental and Optometric services are provided at discounts to Qua Qui referred patients. These cooperative agreements have resulted in the best means of providing cost efficient, quality assured health care.

Qua Qui Corporation has documented (monthly unduplicated count of patients) to have served 1,785 patients during Fiscal Year 1980-81. This number of unduplicated patients receiving health related services is remarkable considering Qua Qui Corporation's Health Program consisted of only two (2) full-time positions funded by the Indian Health Service. Qua Qui was able to acquire much supportive medical staff by way of community volunteers. All nursing manpower was donated by community registered nurses and faculty and student nurses from the University of Montana. During FY 80-81, Qua Qui benefited from the expertise and dedication of fourteen (14) nurses.

A documented number of 11,467 health related services were provided by Qua Qui Corporation's Health Program in fiscal year 1980-81. Categorical services included:

(1) referrals by outreach, (2) contracted physician outpatient visits and affilated lab and X-ray services, (3) perscription services, (4) dental exams and preventative services, (5) contracted optometric exams and supplemental payments for glasses, (6) elderly nutrition services, (7) and preventative outpatient care provided by clinic nurses.

Total FY 80-81 Indian Health Service funding allocated to Qua Qui for the above direct and contracted health care provisions was $31,425.00. Taking this into consideration and in view of the documented patient count of 1,785 patient cost per encounter for FY 80-81 is $17.60. Total contracted dollars (FY 80-81) $31,425.00

Total patients served (FY 80-81) ÷ by 1,785

Patient cost per encounter (FY 80-81) = $17.60

This amount is something to be proud of in view of the fact that before Qua Qui's clinic was established, the Native Americans of Missoula were accustomed to paying triple this amount for health care by resorting to hospital emergency rooms.visits for diagnosis and treatment.

Indian Health and Education Center

125 Commercial Avenue
P.O. Box 2612
Great Falls, Montana 59403
Ph. (406) 761-3165

SELF DETERMINATION THROUGH EDUCATION

EXECUTIVE DIRECTOR
Edward M. LaMere

October 23, 1980

Colonel James Crouch
341st SMW/CC
Malmstrom Air Force Base 59402

Dear Sir:

Enclosed you will find our formal porposal for health care services which we are requesting from Malmstrom Air Force Base.

This proposal has been developed after a series of meetings with Major Fred T. Hight, Jr., Malmstrom Hospital Administrator, and members of our staff and Governing Board. It is our hope at this time that the full range of Health Services which are currently being provided by the Malmstrom medical facility can also be made available to eligible members of the Native American Community on a gradual phase-in basis. For your information we have also included a proposed phase-in schedule.

Please give our proposal your serious, and hopefully, favorable consideration as we feel a cooperative agreement between our agency and the United States Air Force would result in much-needed health services for the Native American people in Great Falls and should be good justification for increased appropriations for the Malmstrom Base Hospital.

Respectfully yours,

AudRey Kromarek
AudRey Kromarek, Chairperson
Board of Directors

AK/jm

cc: Major Fred T. Hight, Jr.
Hospital Administrator
Malmstrom A.F.B. 59402

Edward M. LaMere, Executive Director
Indian Health and Education Center

M.U.I.A. Health Department

PROPOSAL FOR HEALTH CARE SERVICES

SUBMITTED TO

MALMSTROM AIR FORCE BASE HOSPITAL

OCTOBER 23, 1980

BY THE

GREAT FALLS INDIAN HEALTH AND EDUCATION CENTER

AUDREY KROMAREK, CHAIRPERSON

EDWARD M. LAMERE, EXECUTIVE DIRECTOR

The attached proposal for the delivery of health care services to the Great Falls Native American community is being sumbitted for corsideration of a cooperative agreement between the Federal Government and a private non-profit organization supported through Federal Funds. Through the establishment of P.L. 94-437, Title V, Native Americans living in Urban Off-Reservation areas became entitled to use of Federal dollars for health care improvement. As with all federally funded programs, it is the responsibility of the funding agency to coordinate with existing resources to ensure maximum utilization of Federal dollars.

It is our belief that through a coordinated agreement for providing health care services to the Native Americans in the Great Falls area, the results received will benefit Malmstrom Air Base Hospital as well as provide many of the unmet health care needs of the Native Americans it could potentially serve. Through serving the more than 4,000 Native Americans through a gradual assimilation process, the population count which the Air Base could justify, would entitle them to a substantial increase in health care collars. At the same time through servicing a more varied population, the physicians and their supportive staff would be able to continue their growth in working with varying disease entities.

At the present time the Great Falls Indian Health and Education Center has a minimum amount of contract dollars available with which they are provided services by private physicians in the Great Falls area. Due to the lack of funding available, weekly trips are made to the Rocky Boy Service Center for the majority of the health care needs. Not only are the trips an all day project, but in the winter months it is a treacherous one; not to mention the presently used Van being burdened with more than 150,000 hard miles on its wheels.

BACKGROUND ON THE HEALTH CARE NEEDS OF THE GREAT FALLS NATIVE AMERICANS

The Great Falls Indian Health and Education Center serves an average of 57 outpatient visits per month for treatments ranging from hypertension screening, to diabetic testing, to dental and optometric care needs. The majority of these outpatients are transported to Rocky Boy Service Unit for care. With increasing transportation costs and the necessity of making appointments two weeks ahead of time for staffing availability at the Service Unit, the practicality of such a health care delivery system warrants the need for a more efficient system accessible to the Great Falls Indian Community.

The enclosed proposal will be submitted in a "phase in" format which will allow both the Great Falls Indian Center and the Malmstrom Air Base Hospital to assess the impact of the health care services being delivered to the Indian Community via the Air Force Base. It is anticipated, with both parties in agreement, that the services could begin in the areas of pharmacy, training, and lab work within the next thirty days, with full outpatient services being available by January 1, 1931 as noted in the following outline.

PROPOSAL: In pursuit of guidelines established by Section 504, Public Law 94-437, dated September 30, 1976, this proposal is submitted as a foundation for negotiations to begin between Malmstrom AFB, Hospital and the Great Falls Indian Health and Education Center to provide comprehensive health care to the "urban" Indian population of the Great Falls area. The proposed guidelines set forth herewith are not final nor binding. Their intent is to provide a format from which to construct a finalized contract. Any contract for care agreement entered into by the governing Board of Directors of the Great Falls Indian Health and Education Center and the United States Air Force Officials for health care delivery shall be contingent upon final approval of said parties.

GOALS: To provide a comprehensive health care delivery system to the "urban" Indian population of Great Falls. This program will be administered jointly by the Great Falls Indian Health and Education Center and United States Air Force officials.

POPULATION INFORMATION OF THE GREAT FALLS TARGET GROUP

The Indian population served by the Great Falls Indian Health and Education Center is estimated to be between 3500-10,000 depending on which source of information is utilized. County Welfare personnel list 3500 persons as welfare recipients, while they estimate this is thirty (30) percent of the total population living in Cascade County. The Great Falls Alliance shows a figure of 8,600 recipients of care for the past year.

Based on the state average approximately 70 percent of the service population is not covered by insurance of any form. This figure would tend to hold true as the 3500 welfare recipients listed, equate to approximately 30 percent of the service population.

Information gathered over a 12 month period October 1979 - September 1980 shows a total of 689 physician visits or an average of 57 per month (see attached data sheet #1), at an average cost of $36.64 per visit including lab and X-ray expenses. Pharmacy average expenditures per client are $1.76. Hospitalization expenses are not available as the Great Falls Indian Center does not provide funding for inpatient care. These figures do not represent a true cost per visit expenditure as a small portion of the physicians visits are on a gratis basis, and 25 percent of all medications dispensed are obtained at Rocky Boy Health Clinic. By examining these figures more closely it can be assumed that this target population is not properly cared for medically.

BENEFITS TO BE DERIVED FROM INTERAGENCY AGREEMENT

By the United States Air Force and Great Falls Alliance entering into an agreement for health care delivery to the urban Indian population both parties can benefit. The Air Force Hospital could more fully utilize existing facilities and personnel in the following manner. Patient work load would increase with a broader scope of illnesses being presented for treatment from an expanded population with a varying age classification. The health professionals would realize an opportunity to provide therapy to a population other than their normal healthy adults on active duty; thereby, affording them to apply and expand their professional knowledge.

Other benefits to be realized by Air Force personnel would be in the area of public relations, by providing a valuable and necessary community service. An opportunity for recruitment into the armed forces health careers of a minority group, which in the long run would benefit both the military and Indian goals of self reliance.

Great Falls Indian Health and Education Center would realize a goal of being able to satisfy the health needs of their population; thereby, releasing funds for other areas of health care not presently being offered and not available at the Air Force Hospital. Secondly, the health providers at the Center would be able to practice their skills in conjunction with base medical personnel hence, broadening their expertise of knowledge and also assisting the hospitals staff. Center medical personnel would be afforded the opportunity to attend training sessions and in-service continuing education programs being offered at the base.

PRELIMINARY STEPS TO BE TAKEN

ADMISSIONS: In order to assure an understanding as to the procedure for admission to the Air Force Base hospital, all Native Americans seeking health care services through the Great Falls Indian Education Center agreement will be escorted to the Base by the Indian Center Clinic Staff. No admittance will be allowed without prior registration with the Great Falls Indian Center. At a later date, if the need is warranted, Identification cards will be issued stating the limited privileged usage for the individuals.

All patients to be seen at the Malmstrom AFB Hospital shall be screened by the Great Falls Center clinic nurse prior to admission to the hospital facilities, at which time the appropriate referral shall be made to the specific clinic indicated by the nurses' assessment. All health records maintenance shall be the responsibility of the Great Falls Indian Center

Registered Nurse and Health Coordinator until such time that the Air Base staff is able to learn a new recording system without any additional burden on their personnel. The Indian Health Service Form #HSA 369 (4-78) PCIS entry data form shall be completed with the patient's identification and nurses assessment portion filled in. This form shall be signed by the center nurse to verify eligibility for the base medical care. The Center's Registered Nurse, or other designated personnel, shall call the hospital appointment desk to schedule an appointment in the indicated clinic facility. At the time of the appointment, the patient shall be escorted by center personnel in a timely manner to the base clinic with the appropriate PCIS data information.

MEDICAL RECORDS MAINTENANCE:

Medical records shall be maintained at the medical records section of the Malmstrom Air Force Base Hospital. All Indian Health Center records shall be maintained separately from the records of the on base personnel, dependents and veterans. Entry into the files shall be limited to the medical personnel only at the base and the Indian Center Registered Nurse. All filing shall be done by the nurse or health director only, although Air Force personnel shall be able to pull medical records at such times as the Indian Center personnel are not available.

PERSONNEL RESPONSIBILITIES:

The Great Falls Indian Health and Education Center shall furnish a registered nurse to work at the Great Falls AFB Hospital for a specified number of hours as agreed upon by the two parties. The Registered Nurse shall be responsible for but duties not limited to:

1. Compiling medical records, screening patients, filing medical documents in the respective Indian Center files at the AFB Hospital Records Department.

2. Assist Base Hospital personnel and physicians as designated by on duty staff.
3. Attend in-service training and continuing education programs at Malmstrom Air Force Base which will benefit the professional capabilities of the medical staff.
4. Work as a contact/liaison person at Malmstrom AFB for the Indian community.
5. The Registered Nurse shall be available when her time allows to assist physicians and peers in the delivery of health care services. This person shall be responsible to the Commander of the U.S.A.F. Hospital while practicing her profession at Malmstrom.
6. The Registered Nurse will transport any necessary client medical records for transfer to the record system which will be maintained at the Base.

OUT PATIENT VISITS IDENTIFICATION OF THOSE PERSONS ELIGIBLE FOR SERVICES

ID Cards shall be provided by the Great Falls Indian Health and Education Center. Information provided on said ID Card shall be:

1. Patients full name - Last, First, Middle Initial
2. Patient Identification number with a 100 series prefix to identify urban Indian status.
3. Social Security number if available - if not then sponsors, guardians will be utilized.
4. Date of Birth
5. Color of hair
6. Color of eyes
7. Sex
8. Limited privilege usage - shall designate authorized use of medical facilities only.
9. Tribal affiliation
10. Insurance coverage - if applicable

ENTRY INTO HEALTH CARE SYSTEM

1. All patients to be seen at Malmstrom AFB Hospital shall be screened by the Great Falls Center Clinic nurse or health director. At which time the appropriate referral shall be made to the specific clinic indicated by the nurses assessment.
2. Indian Health Service Form #HSA 369 (4-78) PCIS Entry Data form shall be completed with the patients identification and nurses assessment portion filled in. This form shall be signed by the center nurse, health director or alliance director to verify eligibility for base medical care.
3. The verifying authority shall call the base hospital appointment desk to schedule an appointment in the indicated specialty clinic.

MEDICAL RECORDS SECTION AT MALMSTROM A.F.B. HOSPITAL

Medical records shall be maintained at the medical records section at Malmstrom Air Force Base Hospital.

1. Indian health care records will be maintained separately from all other health care records in a lockable file cabinet.
2. Entry to file shall be limited to medical personnel only.
3. All filing shall be done by the nurse or health director only. Although Air Force personnel shall be able to pull medical records during those times Alliance personnel are not available.
4. Health care records shall be pulled prior to a scheduled appointment and delivered to the appropriate clinic.
5. Great Falls center personnel shall be responsible to insure that each patient has a medical folder compiled before each/ or all visits.
6. PCIS form distribution - 3 copies shall be returned to the record filing center in a completed form - minus coding of illness or injury. At which time the alliance personnel shall code and make distribution of the PCIS form in accordance with established procedures.

7. Lab, X-ray, mis. reports will be so designated or indicated so as to return to the urban Indian filing system for inclusion into the health care record jacket in chronological order of visit.

8. Laboratory and radiological reports shall be maintained on the left side of the jacket on separate sheets, in chronological order behind the PCIS data forms.

9. Patient demographic data and identification forms shall be maintained on the right side of the jacket. All other forms and physicians notes are located on the left in chronological order. Patient consent forms and privacy act statements shall be located on the right side of the jacket behind all other forms.

MALMSTROM AIR FORCE BASE SHALL PROVIDE:

1. Out Patient care
2. Follow-up out patient care
3. Emergency room visits
4. In patient care
5. Transfer of patients to other facilities.
    - a. Other military facilities.
    - b. V.A. Hospital
    - c. Private hospitals (non-government)
    - d. P.H.S. care facilities
6. Pharmacy Care
    - a. Those clients having been designated as eligible for care at base facilities shall be eligible for all pharmaceutical supplies at the base hospital.
    - b. Those recipients of care under the urban Indian provision of the law, for which health care was not provided at the base, but for which a prescription is required to be filled may elect to have it filled at the base hospital pharmacy if they stock that medication.

7. Optometry services not to include Opthamology
    a. Initial screening will have to be accomplished at the base optometry clinic
    b. Refraction examination - cyclcplegic eye refraction and normal refractions shall be accomplished by base personnel with eye glasses being furnished by DOD sources if the patient so desires. Alternative method is to have the optometric prescription and eye glass measurements furnished to the patient for local purchase.
8. Obstetrical/Surgical Care - All services under these two departments will by virtue of the fact they do not presently exist at Malmstrom have to be referred to private physicians and local community facilities until such time as they may be available at the base.
9. Dental Services
    a. To provide those dental services to the urban Indian population of Great Falls Identical services as are available to Military dependents. (Screening only to dependent children no other dental services.)
10. Mental Health
    a. To provide those mental health services to the urban Indian population of Great Falls identical services as are available to military personnel.

BASE ENTRANCE FOR MEDICAL

In lieu of the fact that base security is necessary and tight some means of admittance for medical appointment is necessary, therefore, alternative methods for entry must be proposed for acceptance.

1. Issue each eligible patient certified by the center an identification card, at a later designated date. Showing health care privileges only. This ID card may be used for admittance.

2. Issue the Alliance three vehicle stickers to be placed on the Alliances Van, the Registered Nurse and Health Director's vehicles which would allow admittance to the Base.

IMMUNIOLOGY SERVICES

In order to provide a full realm of health care it must be considered that preventative measure are a viable aspect of that system. So as to provide sufficient preventative measures full immunizations should be included in these services to include normal regional innoculations required by the U.S.P.H Department, routine immunizations to prevent Diptheria, Tetanus, Mumps, Measles/polionyletis and rubella. Routine screening and detection for Tuberculosis as prescribed by the U.S.P.H Department.

Immunizations shall be appropriately logged in a health record as currently in use by the Armed Forces. All positive Tuberculosis convertors shall be reported through County Public Health Department officials with subsequent follow-up and therapy procedures being followed in accordance with current theraputic practices as prescribed by U.S. Public Health Department regulations.

ATTACHMENT #1

Great Falls
Indian Health and Education Center

MEDICAL DELIVERY COSTS

October 1979 - September 30, 1980

October	Patients	66
	Physicians	1484.95
	Pharmacy	281.60
	Average physician cost per patient	26.76
	Average pharmacy cost	4.26
November	Patients	49
	Physicians	1081.00
	Pharmacy	281.60
	Average physician cost per patient	22.06
	Average pharmacy cost	5.74
December	Patients	46
	Physicians	2051.00
	Pharmacy	584.60
	Average physician cost per patient	44.59
	Average pharmacy cost	12.71
January	Patients	76
	Physicians	418.85
	Pharmacy	203.11
	Average physician cost per patient	5.51
	Average pharmacy cost	2.67
February	Patients	43
	Physicians	1709.55
	Pharmacy	274.46
	Average physician cost per patient	39.75
	Average pharmacy cost	6.38
March	Patients	48
	Physicians	3059.65
	Pharmacy	721.52
	Average physician cost per patient	63.74
	Average pharmacy cost	15.03
April	Patients	76
	Physicians	1286.95
	Pharmacy	349.36
	Average physician cost per patient	16.93
	Average pharmacy cost	4.59
May	Patients	80
	Physicians	1571.70
	Pharmacy	493.52
	Average physician cost per patient	19.64
	Average pharmacy cost	6.16
June	Patients	58
	Physicians	1610.65
	Pharmacy	504.85
	Average physician cost per patient	27.76
	Average pharmacy cost	8.70
July	Patients	88
	Physicians	2271.20
	Pharmacy	630.02
	Average physician cost per patient	25.80
	Average pharmacy cost	7.15
August	Patients	31
	Physicians	2055.35
	Pharmacy	1043.21
	Average physician cost per patient	66.30
	Average pharmacy cost	33.65
September	Patients	28
	Physicians	1097.15
	Pharmacy	182.75
	Average physician cost per patient	39.18
	Average pharmacy cost	6.52

PROPOSED TIMEFRAME FOR IMPLEMENTATION OF SERVICES

	1980		1981											
	Nov.15	Dec.	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Begin use of pharmacy for filling of prescriptions supplied through local physicians Maximum of 10 prescriptions filled per week	X													
Begin use of optometric services available - screening and fitting of eyeglasses. Maximum of 5 clients per week.		X												
Begin use of Laboratory services for blood and urine for hypertension and high/low blood sugar. Maximum of 5 clients tested per week.	X													
Begin use of x-ray services as available on an "emergency" basis during regular office hours. Maximum anticipated usage of 3 clients per week.		X												
Begin use of outpatient services as per "agreement" with hospital/clinic staff. Maximum usage of 10 clients per week.		X												
Begin use of dental facilities once a week for a three hour evening session with two dentists on duty. Basic use for screening and flouridation treatments of children to age 16. Maximum of 10 clients per session.		X												

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

TO : Pharmacy Program

DATE: November 13, 1981

FROM : Service Unit Director
Rocky Boy's Service Unit

SUBJECT: Prescriptions

You are hereby directed to no longer provide prescriptions to patients who do not physically present themselves to the pharmacy.

Exceptions can be made for local bedridden patients who are under the care of the community health nurses or the Community Health Representatives.

This policy directive is effective November 1, 1981.

Duane E. Jeanotte

12/16/81

To Whom it may Concern:

I am Writing this letter to inform you What the Indian Urban Health Center has meant to me. My Husband is Retired and Unable to find Work, So We are living on a Pension that is hardly adequate to Cover the Cost of living. I am disabled (L. Leg Amputated) I have been Doctoring for the past 21 yrs. 2 open Heart Surgery's - Gall Bladder Surgery - Hysterectomy - Blood Clots in (L) arm & Leg.

I am taking a Horrendous Amt of Medication the last 2 yrs. the Indian Health Center has provided me with These - "God Bless" this program I have recived nothing but Kindness from the people involved in this program, I have a Blue Cross Insurance policy that is very limited & have just recieved Notice it will go up to $135.00 Per Month We are facing the New Year With "What Next". We are not old enough for Social Security and have no other Source of Income. I recieved Some Help at the Blackfeet Indian Hosp. but Was faced With driving up there every-Month. With the price of Gas it Wasn't possible for me to do this. I am also Diabetic & have had problems With my good leg Swelling Since July of this year When my Blood Thinner Caused Hemorrhaging in the Knee and Thigh. I never get Caught up With Dr. & Hosp. Bills because They are Continuous.

May I ask that you have Compassion When you Consider Keeping this Program Alive. I am Sure there are Others as desperate as I am. This Would be a God-send to me this Holiday Season.

Thank! You
Mrs. June Kelley
321 Riverview 4, W.
Great Falls, Mt. 59404

December 16, 1981

Dear Committee Members:

I have been using the services at the Native American Center since 1978.

They have helped me arrange medical, dental and eye appointments in Rocky Boy. I have used their transportation for these appointments because my car is old and needs frequent repairs if used very often and I have no way of buying gas except at the first of the month when I get my Social Security check.

One of the doctors at Rocky Boy sent me to a doctor here in Great Falls in June of 1979 because I developed Diabetes. After I was in the hospital I discovered that Rocky Boy was not going to help me with my medical bill because I do not live on the reservation. The Native American Center has helped me by sending their nurse to my house to teach me about my diet and to check my blood pressure as my doctor orders, without my having to pay the high amount the hospital was charging to send their nurse.

I was told I again had to go to Rocky Boy to see the doctor in order to get all of my pills filled. I have to take four (4) different pills four times a day, along with Insulin, needles, alcohol swabs and testape. I saw the doctor in Rocky Boy and he told me he wouldn't touch me because I have a specialist in Great Falls. He said I can get my pills filled but I need a new written prescription every six months.

Why sirs, does the reservation make me travel all those miles if their doctors won't treat me. This is happening to many of my friends too. I do want to thank the Center for all their help and to tell you, that I would not be able to survive without their help because they are always around to explain what I don't understand and to help me follow my doctor's advise.

Thank you,

Mrs. Agnes Lambert

December 16, 1981

Dear Sirs:

I have been having my eyes tested in Rocky Boy for the last couple of years, and my teeth worked on. I have dentures now but this last week when I went to Rocky Boy, they told me it would cost me $130 to have them religned. Also, when I need new glasses it will cost me atleast $50 for bifocals. On my Social Security I can barely make ends meet, so are all of the reservation people being charged this much? Am I being charged because I had to move off the reservation to find work?

If it were not for the Native American Center, I wouldn't have gotten my dentures and I would not have been able to travel to Rocky Boy. If we lose our Center where will I find the advise I need to make ends meet?

Thank you,

Mr. Stephen Lambert

Stephen Lambert

December 18, 1981

Good Morning Mr. Chairman and Committee Members:

I'm on a fixed income and can't afford to pay for medications or dental work. I went to the Rocky Boy Health Clinic six times for dentures and could not wear them. After getting them filed down, they still don't fit. I also got glasses from them but I can't wear them either. I was having so much trouble, the Native American Center helped me organize my expenses and through the Welfare department finally helped me obtain medical help.

My bones are deteriorating and I have to take pain pills for this. I sent for some tylenol from Rocky Boy and they sent only 24 pills to last me all month. I have to take two pills every four hours. So when I ran out of pills, I went to the Native American Center and they gave me a bottle. I know that the Center has a limited pharmacy budget and I hate to ask them all the time.

I'm wondering if Rocky Boy is too overloaded with patients that is why they don't provide good services. Why can't more money be given to all Indian programs? How come when they start cutting programs, the Indian programs are the first ones to be cut?

I would just like to say that Indian programs should have more funds to operate with to help poor people like me.

Thank you,

Mrs. Delevene Lane

501. 23 AVE. N E.
GT. FALLS, MONT.
59404

TO WHO IT MAY CONCERN

I WOULD LIKE TO EXPRESS MY FEELINGS ABOUT THE INDIAN HEALTH AND EDUCATION CENTER.

I FEEL THE NECESSARY OPERATING FUNDS SHOULD BE MADE AVAILABLE TO THEM BECAUSE I KNOW PERSONALY OF SEVERAL FAMILYS THEY HAVE HELPED, MY PARENTS INCLUDED.

MY MOTHER IS ONE OF THOSE UNFORTUNATE ONES THAT HAS HAD CANCER THREE TIMES. SHE ALSO HAS DIABETES AND VARIOUS OTHER HEALTH PROBLEMS. HER MEDICINE ALONE COMES TO WELL OVER ONE HUNDRED DOLLARS PER MONTHS FOR THE PAST YEAR THE INDIAN CENTER HAS BEEN BUYING MOST OF HER

MEDICINE. I JUST DON'T KNOW WHAT WE WOULD HAVE DONE WITHOUT THIER HELP. I TRIED OTHER AGENCY'S FOR HELP BUT GOT NO RESULTS UNTIL THE INDIAN CENTER HELPED ME AND BELIEVE ME I APPRECIATE THIER HELP.

Mrs Carl Schultz
Great Falls, Mont.

Senator MELCHER. Kenny Nicholson.

STATEMENT OF KENNY NICHOLSON, HEALTH DIRECTOR, BILLINGS HEALTH CARE ASSOCIATION, ACCOMPANIED BY BERNADETTE SHERETTE, EXECUTIVE DIRECTOR, BILLINGS AMERICAN INDIAN COUNCIL

Mr. NICHOLSON. I am the health director for the Billings American Indian Council here in Billings. On my right is Bernadette Sherette, executive director. I am also testifying on behalf of the American Indian Health Care Association, which is a national association that represents 41 urban projects around the country.

First, I would like to testify on behalf of the Billings American Indian Council. There are approximately 5,000 Indian people residing in the city of Billings. Our health program outpatient clinic services an estimated number of 2,500 Indian clients and patients.

Fiscal year 1982 budget cuts will have an adverse effect on our already underfunded program, the services it provides, and most importantly, the patients. Of the Indian people utilizing the Billings American Indian Council's health program and outpatient clinic, 2,125 (85 percent) have no medical insurance. These patients, when ill, will end up in an emergency room and one-third of these patients will be hospitalized unable to pay the doctor and hospital bills. The budget cuts will also affect the infants, preschoolers, students, pregnant women, and the unemployed who rely on the services we provide. Thirty percent of the patient registration at the clinic are unemployed. These patients cannot afford to pay for health care.

If budget cuts are to be made, cut the unnecessary administration from IHS headquarters and the IHS area offices. When cuts are made by IHS, they use urban Indian health programs as sacrificial lambs.

In closing, the Billings American Indian Council requests that the members of this committee continue their support of all Indian health programs and the people they serve. Thank you.

Senator MELCHER. Thank you. Lois Fallis.

Mr. NICHOLSON. I am still going to submit one. I am submitting this testimony on behalf of the American Indian Health Care Association, for which I am a board member at large.

On behalf of the American Indian Health Care Association, I wish to thank the committee for the opportunity to testify and to comment on the fiscal year 1982 budget cuts on urban Indian health.

The current political climate, administrative policies, and delays in the legislative process during the 97th Congress have all combined to create a negative impact upon urban Indian health.

A delay in enacting the interim appropriations bill due to the administration's late request for an additional 12-percent cut the day before Senate consideration of the bill in September necessitated three continuing resolutions and the application of the deferrals are all factors that have had an adverse effect upon the delivery of health care to urban and rural nonreservation Indians.

In addition, this administration's refusal to honor the Federal Government's obligation and responsibility for providing health care to all eligible American Indians, regardless of where they reside, has resulted in a policy to eventually phase out urban Indian programs. This proposes a real threat to the survival of these programs. Indian Health Service has pursued a decentralized policy in applying the stop-gap legislation. It was left to area Indian Health Service directors to determine the level of funding and period of contracting under the continuing resolution. The amounts withheld under the deferrals have varied from area to area and have ranged literally from 0 to 100 percent. Some areas have chosen not to contract with urban projects because the Senate did not appropriate any money for title V programs and its version of the Interior appropriations bill. In most cases the area Indian Health Service has contracted on a 30-day basis and has allowed for the extension of contract with carry-over funds. The uncertainty of funding and its effort to keep doors open until completion of the appropriations process, many projects reprogramed their fiscal year 1981 funding, extending their contracts, but did not obtain additional funding under the continuing resolutions. This had the effect of severely curtailing services and effecting the employment of Indian Health personnel. Many of the services cut were contract care, medical specialties; for example, cardiologists, optometrists, O.B./GYN, pharmaceuticals, X-rays, laboratory, dental, transportation, home health care, health education, and social services. In some situations all satellite clinic services were discontinued in anticipation of cuts in funding. Those projects not affected are those whose fiscal year 1981 contracts have not expired or who have other resources.

Those employees who were laid off or whose hours were curtailed were primarily allied health personnel of Indian descent. These individuals received their training because of the efforts of urban Indian health programs. Many are single parents, female, heads of households. Out of necessity most primary health care providers were retained but found themselves working longer hours and spending less time with clients. This severely compromises preventive health care.

Other budget cuts and resultant changes in agencies policies also adversely affect Indian Health Care. Change in State medicaid and medicare policies in response to Federal legislation and cuts in funding to the States for those programs are severely mitigating against the generation of three party funds for urban Indian health care programs. Stricter eligibility criteria will severely limit Indian participation in these programs. In addition, many physicians throughout the country are refusing to treat medicaid patients because of ceilings placed on reimbursement. The re-designation of some areas as health manpower shortage areas will remove some National Health Services Corps personnel from some clinics and will hamper the development of some urban projects who are now just beginning to provide primary medical and dental services. Cuts in funding for the National Health Services Corps will not allow for new placement of professional personnel simply because their salaries cannot be paid. The closing of the Public Health Service hospital, particularly in Seattle and Boston, will have a negative impact upon the provision of in-patient care and auxiliary services.

Heretofore the abilities to generate an equal amount of funding from other resources will be severely curtailed by health service block grants. Urban Indian health projects must now compete on the State level for limited funding. Urban Indian health organizations are not eligible for the funding set aside for tribes and tribal oragnizations under the block grants. I would also like to state that the American Indian Health Care position has always been that they will not compete with the tribes for different moneys.

A survey conducted among urban Indian health care programs revealed that many unique services provided by these programs are not available elsewhere in their communities. Title V dollars assume increased significance in light of the political climate. They are absolutely essential to the survival of urban Indian health care programs whose sole purpose is to deliver health care to one-half of the total population of American Indians residing in this country.

For this small investment, the Federal Government has realized significant gains in the health status of Indian people in accordance with the Indian Health Care Improvement Act. Urban Indian health programs have, in fact, increased access to health care in a cost effective manner and have changed patterns of utilization of the high cost of health care; for example, emergency, preventing hospitalizations.

The urban Indian health programs have sustained only an 8 percent cut—from $8.9 million to $8.16 million—when the administration wanted a 62 percent cut. Even this small cut of $74,000 will have a significant impact on an already lean program. This loss is a significant amount when the total funding structure of these programs is reviewed. Most of the 41 projects received funding in the range of $82,000 to $200,000. Clearly the manner in which the cuts to the title V funding will be handled is a matter of grave concern to the AIHCA and its 41 member projects. The evaluation of urban projects that are now required by Congress will largely determine how the cuts will be distributed. The AIHCA wishes to go on record as recommending fair and impartial evaluations and that they be included in the administrative process that will plan and execute the evaluations.

In conclusion, and to reiterate, the current times are paralyzing and all face an uncertain future. Ultimately the people who will suffer from a severe curtailment and/or discontinuance of their health services are the Indian people themselves. The AIHCA requests that the members of this committee continue their support of urban Indian health programs and that they take an active role in insuring their survival.

Thank you.

Senator MELCHER. Thank you, Kenny.

Lois Fallis.

Mr. NICHOLSON. On behalf of Lois Fallis, she had to leave, and this will be her written statement for the record.

Senator MELCHER. We will make your statement and that of Ms. Fallis a part of the record at this point.

[The statements follow. Testimony resumes on p. 273.]

Testimony

Submitted to the

Senate Select Committee on Indian Affairs

December 21, 1981

Ken Nicholson, Board Member
American Indian Health Care Association

The American Indian Health Care Association wishes to thank the Committee for the opportunity to testify and comment on the impact of the FY-82 budget cuts upon Urban Indian Health.

The current political climate, Administration policies and delays in the legislative process during the first session of the 97th Congress have all combined to create a negative impact upon Urban Indian Health.

The delay in enacting the Interim Appropriations Bill (H.R. 4035) due to the Administration's eleventh-hour request for an additional 12 percent cut the day before Senate floor action, the necessity of three (3) Continuing Resolutions, and the application of deferrals to the CRs were combining factors in creating an adverse effect upon the delivery of health care to urban and rural non-reservation Indians. Though the Administration's March budget request cut Title V funding by 50 percent, under the additional 12 percent cut requested in September, the Administration intended to phase out these programs in FY 82 instead of FY 83 as originally stated. The refusal to fund these programs represents an unwillingness to honor the Federal Government's obligation and responsibility for the provision of health care to all eligible American Indians, regardless of where they reside.

Since IHS pursues a decentralized policy in administering its program, the actual effect of the deferrals varied from area to area. Some areas withheld all funds, while others withheld as little as 2 percent. In most cases, the programs whose contracts were up for renewal literally did not know until the last minute of each deadline whether they would be open the next day. IHS did contract on a 30-day basis in some cases and allowed for extension of contracts. The latter action made the programs ineligible for funding under the CR, but was a course of action chosen by many because it was felt that it was more important to keep doors open even at a reduced service level. The reprogramming of funds required a cut in services and personnel. Hardest hit were allied health personnel of Indian descent. Most of these individuals received their training because of the efforts of the Urban Indian Centers. Of necessity, most primary care providers were retained but found themselves working longer hours and reducing time spent with clients. This severely hampers the quality of care provided. Many of the services cut were contract care for medical specialties, e.g., cardiologists, optometrics, OB/Gyn., etc., and for ancillary services such as pharmaceuticals, x-rays, laboratory, dental, transportation, home health care, health education, and social services. In some situations, all satellite clinics serving small communities were discontinued. Those projects not affected are those whose FY-81 contracts have not expired or who have other resources.

Other budget cuts and resultant changes in agencies' policies also adversely affect Indian Health Care. Changes in State Medicaid and Medicare policies in response to Federal legislation and cuts in funding to the States for those programs are severely mitigating against the generation of third-party funds for Urban Indian Health Care Programs. Stricter eligibility criteria will severely limit Indian participation in these programs. In addition, many physicians throughout the country are refusing to treat Medicaid patients because of ceilings placed on reimbursement. The de-designation of some areas as health manpower shortage areas will remove some National Health Service Corps personnel from some clinics and will hamper the development of some Urban projects who are now just beginning to provide primary medical and dental services. Cuts in funding for the National Health Service Corps will not allow for new placement of professional personnel simply because their salaries cannot be paid. The private service option will also reduce the availability of Corps personnel. The closing of the Public Health Service Hospitals, particularly in

Seattle and Boston, will have a negative impact upon the provision of inpatient care and auxiliary services in these areas.

Heretofore, the abilities to generate an equal amount of funding from other resources will be severely curtailed by Health Service Block Grants. Urban Indian Health Projects must now compete on the State level for limited funding. Urban Indian Health organizations are not eligible for the funding set aside for Tribes or Tribal organizations under the Block Grants.

A survey conducted among Urban Indian Health Care Programs revealed many unique services provided by these programs are not available elsewhere in their communities. Title V dollars assume increased significance in light of the current political climate. They are absolutely essential to the survival of Urban Indian Health Care Programs whose sole purpose is to deliver health care to one-half of the total population of American Indians residing in this country.

For this small investment, the Federal Government has realized significant gains in the health status of Indian people in accordance with the Indian Health Care Improvement Act. Urban Indian Health Programs have, in fact, increased access to health care in a cost-effective manner and have changed patterns of utilization of the high-cost forms of health care, e.g., emergency rooms, unnecessary hospitalizations for preventable illnesses.

The Urban Indian Health Programs have sustained only an 8 percent cut (from $8.9 million to $8.16 million) when the Administration wanted a 62 percent cut. Even this small cut of $740,000 will have a significant impact on an already lean program. This loss is a significant amount when the total funding structure of these programs is reviewed. Most of the 41 projects received funding in the range of $82,000 to $200,000. Clearly, the manner in which the cuts to the Title V funding will be handled is a matter of grave concern to the

AIHCA and its 41 member projects. The evaluation of urban projects that are now required by Congress will largely determine how the cuts will be distributed. The AIHCA wishes to go on record as recommending fair and impartial evaluations and that they be included in the administrative process that will plan and execute the evaluations.

In conclusion, and to reiterate, the current political climate and stated Administration policy leaves the future of Urban Indian Health in doubt. We face an uncertain future. Ultimately, the people who will suffer from a severe curtailment and/or discontinuation of their health services are the Indian people themselves. The AIHCA requests that the Members of this Committee continue their support of Urban Indian Health Programs and they take an active role in insuring their survival.

TRANSCRIPT OF THE STATEMENT DELIVERED BY LOIS M. FALLIS,
EXECUTIVE DIRECTOR, SOUTH DAKOTA URBAN INDIAN HEALTH,
PIERRE, SOUTH DAKOTA,
BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
DECEMBER 21, 1981
BILLINGS, MONTANA

Good morning, Chairman Melcher, members of the Select Committee on Indian Affairs and distinguished guests. My name is Lois Fallis. I am Executive Director of South Dakota Urban Indian Health, Inc., located in Pierre, South Dakota, and a member of the Rosebud Sioux Tribe.

I appreciate the opportunity you have given me to present testimony regarding the impact of proposed 1982 budget reductions on Indian Health Service funded and operated programs. South Dakota Urban Indian Health, Inc. provides clinical health care for the non-reservation populace in Hughes, Stanley and Minnehaha counties of South Dakota. Respectively, those counties contain the communities of Pierre, Fort Pierre and Sioux Falls.

In addition to the direct health care available through our clinical facilities, we have contracted with specialized health care providers in each community to whom we can refer clients who require more intensive care. This contractual relationship has worked extremely well and has filled a critical void in the health care available to non-reservation Indians.

South Dakota Urban Indian Health, Inc., opened its doors with $122,500 in funding, on September 1, 1977. In August, 1980, we received $155,000 in funding for fiscal year 1981. We have been operating on contract modifications since that funding expired. We began providing contract health care in the summer of 1980, and expanded to provide clinical services in July, 1981, in the Pierre/Fort Pierre service area only. Sioux Falls began this fall.

The funding we have received provides health care to approximately/2,500 off-reservation Indians who otherwise would not have access to any subsidized care within reasonable driving distances.

During the Fiscal Year 1980 reporting period, our first year of clinical operation, South Dakota Urban Indian Health handled 1,489 health care cases, involving 1,123 clients. Those figures increased dramatically in Fiscal Year 81 when we handled 5,830 cases which included 1,830 medical clients, 150 dental, 1,110 prescriptions, 320 optical and 2,420 contacts with other problems. The latter category included home visits, referrals, family planning, health and nutrition education, mental health counseling, alcohol counseling and general social services assistance.

Our service population is almost exclusively North and South Dakota Sioux. Most are low income, economically disadvantaged and socially deprived. Although our clients are generally tribal members, they rarely have access to tribal health services because of the vast distances involved or as a result of management decisions which exclude non-reservation residents from health service. Once excluded from service, our clients have no alternative but to forego adequate health care or to travel many miles to a Public Health Service facility. Naturally, such impediments to a minimum standard of health care lead to a massive deterioration in the general health level of off-reservation residents. We have reversed that deterioration. We are making progress. We have a highly qualified board and staff. Further budget cuts will seriously affect our ability to serve our clientele. In addition, we will face the prospect of losing all or part of a staff of eleven, five of whom are tribal enrollees. The staff includes four doctors who volunteer their services to us in Sioux Falls, a recently hired drug counselor in Sioux Falls, a four-year medical technologist, an LPN, a certified medical assistant, a physician's assistant and an administrative staff with a combined experience of over sixty years in two positions!

Our three person board includes Dr. Max Dickens, a clinical psychologist from Fort Berthold, North Dakota; Kay Rehfeld, a Cheyenne River Sioux who is an RN with the Brown County Health Department and Chairman Cato Valandra, who is director of the Institute of Indian Studies at the University of South Dakota and a former chairman of the Rosebud Sioux Tribe.

Mr. Chairman, members of the Committee, my message is short and to the point. I will not take up any more of your time. My sole purpose was to demonstrate that we have a good program. It works. We have a superior staff to support our mission. We have built that staff on trust. We haven't squandered our money. That money has provided direct health care to nearly/2,500 non-reservation Indians who, over a two year period, have had nearly 7,500 contacts with our services. Those figures, in black and white, translate into human beings in desperate need of adequate health care. Health care which only we can provide.

Previous budget cuts have forced us to reduce our service area. ~~Last~~ this year we dropped Yankton and Brown Counties from service because we just couldn't do the job with the money available. We are now concentrating on the three most critical counties. We cannot reduce any further. To do so will cripple the program and perhaps kill it; but, most assuredly we will lose portions of a staff which is unequaled in ability.

We must receive adequate funding to exist. Any further budget cuts will cut service even further. It is as simple as that.

I will be submitting additional written testimony to supplement what I have provided to you today.

Thank you for your attentiveness. I appreciate the opportunity to speak and would be happy to address any questions you may have.

Senator MELCHER. Our next witness is John James.

STATEMENT OF JOHN JAMES, ACTING DIRECTOR, CLINIC SERVICES, MILWAUKEE INDIAN HEALTH BOARD, MILWAUKEE, WIS.

Mr. JAMES. I am the acting director of clinic services with the Milwaukee Indian Health Board. We are a phase IV urban health program, which is the highest phase an urban Indian health program can achieve. At that level we are providing a comprehensive range of health care services.

In our particular program we have complete medical and dental care on an out-patient basis. We have pharmacy services, ancillary support services, and social services. It has become an innovative program.

It is not only a model health care program in terms of urban Indian programs, but since we have sought diversified sources of funds, we have been known as a model program, even in the community health center's realm of service delivery.

Presently our program in providing these services has sustained some very severe cuts in terms of some of our other funding sources. As an urban program, we were required to seek other sources of funding, and we have been very successful in doing so.

Up until last year, we were getting over $5 of outside sources of funding for every dollar of Indian Health Service funding. Presently in sustaining these cuts, we have come to realize the increasing importances of urban health care funding to the essential support of our program.

Our program has been shown to have a demonstrable effect on the health status of Indian people in the city of Milwaukee. We have shown that we have been able to effect the rate of inf nt mortality for the Milwaukee urban Indian community, bringing the present rate to a level that is lower than that for Wisconsin Indians in general, and for all races, lower than the inner-city of Milwaukee.

Presently in terms of our obstetric care program, over 77 percent of our clients are seeking health care within the first trimester of pregnancy, which has a noted outcome effect on the health of the unborn child.

Over the previous year we did not have one case of infant mortality in 75 cases of delivery.

We feel that in terms of urban Indian health programs, ours in particular, we have been able to demonstrate that we have had an effect on the health of Indian people in our community.

Presently, 82 percent of our clients are Indian people. To explain a little bit: In seeking out outside sources of funding, such as Community Health Centers funding, we are required to serve anybody who walks through the door. We do have a target population of Indian people, and we effectively have access to the Indian community in Milwaukee.

Presently we are seeing 62 percent of our clients as being below the poverty index. We are serving a higher rate of child and adolescence. Fifty-three percent of our clients are under the age of 18. So we are dealing with people who generally do not have access to the financial means to obtain health care in the prevailing delivery system.

In terms of the funding cutbacks, we have approached private foundations, the private sector, and although they agree we are a worthy program, they say their funding is very limited also. The Federal cutbacks have shown there are many holes in the safety net.

In Milwaukee, in particular, we are seeing cutbacks in terms of the local governmental funding agencies. A local center, the downtown medical complex, which treated indigent and poor people is in the process of closing. There are cutbacks in terms of county funding for health care. The State medicaid program is currently tightening up their restrictions. They are starting copayment mechanisms, spenddown provisions. So, increasingly, the general system is looking to programs such as ours to pick up the slack in what they are no longer able to provide. We are seeing an increasing hardship placed on our program to serve the needs of our community.

We feel that programs that have developed levels of services effectively should be supported. It was a very long and difficult process to get to the point where we were seen as effective deliverers of health care, and it was often costly, but at some point we were found to be cost effective, we were providing care which was known as quality care, it was accessible, available to the community, and we feel that programs that reach this level should receive as much support as possible in terms of Indian Health Service funding.

I think it is important to note that these programs developed as a response to a need during all phases of development. Whether or not these programs are funded or whether or not they are supported, we still believe the need will be there. We feel it would not be very cost effective if these programs were to close down, were to be cut back significantly, and no longer will serve that need because we feel the need would still be there. A few years from now, in a changing climate, we might have to go through that long, expensive and difficult process of developing these programs to where they can provide effective, medically competent, quality care once again.

Senator MELCHER. Mr. James, are your community services eligible for block grants?

Mr. JAMES. We are looking into that possibility, yes. We previously received funding under the State division of maternal and child health which was kind of a precursor of the block grant concept. Previous we received a level of $161,000 per year to meet the maternal and child health care needs of our population. That funding, at this point, has been eliminated.

Senator MELCHER. Is the State of Wisconsin participating in block grants for health care?

Mr. JAMES. They are going to be going in that direction. Under community health centers, the primary care of block grant, I do not believe, will start until 1983.

Senator MELCHER. How about the other two beyond primary care?

Mr. JAMES. I do not have that information this morning.

Senator MELCHER. In preventive health and alcoholism, do you do anything about alcoholism?

Mr. JAMES. There is another alcoholism treatment facility, and we do referrals to them.

Senator MELCHER. You do referrals. Thank you.

Lillian Woodenlegs.

STATEMENT OF LILLIAN WOODENLEGS, ACTING DIRECTOR, INTER-TRIBAL CULTURAL TREATMENT CENTER, VA HOSPITAL, SHERIDAN, WYO.

Ms. WOODENLEGS. My name is Lillian Woodenlegs. I am currently the acting director for the Inter-Tribal Cultural Treatment Center.

I will be going over the direction and brief history. I will have our clinical director, Ozzie Williamson go over the impact this budget cut will have on our services.

Statistically, alcoholism and alcohol related deaths are our No. 1 killers among the Indian people. Alcoholism is 5.5 times the national average.

Suicide is twice the national average. Homicide is three times the national average, and 30 percent of all auto accidents are alcohol related.

The Inter-Tribal Cultural Treatment Center is the only long-term alcoholism treatment center in the United States. It was established in 1972. It is staffed by Native Americans to serve Native Americans, and was funded by NIAAA. The original NIAAA grant was $262,000. That is the only source of funding we have operated on for the past 6 years.

In 1976, we were transferred to Indian Health Service, who had been supplementing our grant with contract medical care moneys. This year the supplementary funds are being cut by 80 percent, $80,000. We were informed by the area director that our current grant had to absorb this $80,000.

In addition, the grant will be reduced by the 7-percent loss in buying power and proposed cut of 10 percent in contract alcohol budget. Overall, the impact will be a 48-percent decrease in our current operating budget.

I would like to have Ozzie Williamson go over the impact it is going to have on our services.

STATEMENT OF OZZIE WILLIAMSON, CLINICAL DIRECTOR, INTER-TRIBAL CULTURAL TREATMENT CENTER, VA HOSPITAL, SHERIDAN, WYO.

Mr. WILLIAMSON. Thank you, Senator Melcher. Last summer when we negotiated with the Indian Health Service for this year's contract, we dropped three counseling positions to try to survive on this budget for this year. Now it is being recommended that we drop six more positions. It is recommended that we drop our night manager, our data coordinator, our medical secretary, and three more counselors.

I do not see any way possible of operating a 24-hour, 7-day-a-week treatment program with three counseling staff, two administration, and myself.

Cutting the position of data coordinator will reduce the ability to provide accurate statistics to support grants and the need for increases. Cutting the position of medical secretary will affect the ability to dispense medication legally. Cutting the position of three counselors will affect the quality of care and the number of persons who we can serve.

The impact on the Indian Health Service, No. 1 is, IHS is unable to provide technical assistance due to travel restrictions, and technical assistance can be provided only in life or death situations.

No. 2, the only person qualified to provide technical assistance is the alcoholism coordinator, who was terminated and cannot be replaced due to Federal hiring freezes and funding restrictions.

No. 3, IHS cannot supplement the contract alcohol budget from other line items because the hospitals and clinics are also being cut.

No. 4, funds for the contract alcohol budget remain equivalent to the original NIAAA transfer.

No. 5, congressional appropriations for this year are to be for evaluation rather than treatment.

Our recommendations are that Congress approve the liquor taxation bill currently in Congress; approve the increase in the contract alcohol budget currently in Congress; and since IHS is not required to be responsive to the input provided by the people, a method should be devised to insure existing funds are distributed in a proportion as needed.

I feel that any cuts in any Indian alcoholism programs is going to add to the costs of hospitalization and clinics. It has been a proven fact that the majority of hospitalization is alcohol-caused and related, and if we cut any alcoholism programs, that cost is going to continue to rise.

Senator MELCHER. Did you say funds should be only used for evaluation rather than treatment?

Mr. WILLIAMSON. That was the word that we got. That they are going to be used for evaluation rather than treatment.

Senator MELCHER. That was a memo or directive?

Mr. WILLIAMSON. No, we called a lady back there—I can't remember her name. She was with the appropriations.

Senator MELCHER. When you laid off three counselors, you are talking about that was the intent of the appropriations?

Mr. WILLIAMSON. No, the three counselors, we laid——

Senator MELCHER. Let me back up. Was the intent of the appropriations that the funds were to be used only for evaluation rather than treatment?

Mr. WILLIAMSON. No, not those funds. I am not talking about that, Senator. The funds that are being cut now, the $80,000 that is being cut, is what is going to affect the treatment we are trying to provide now. The three counselors that we are going to have to lay off December 31.

Senator MELCHER. Where did this evaluation rather than treatment——

Mr. WILLIAMSON. That was just a word we got from Washington when we called back there to find out what was happening this year. We were told once that there was an increase in alcoholism by $1.9 million.

Senator MELCHER. Well, the reduction eliminated the evaluation, but not treatment? Is that the intent, as you understand it?

Mr. WILLIAMSON. Right.

Senator MELCHER. You had to lay off three counselors.

Mr. WILLIAMSON. That is what we will have left.

Senator MELCHER. You will have three left?

Mr. **Williamson**. Three left by the end of December.

Senator **Melcher**. And what did you have before?

Mr. **Williamson**. Six.

Senator **Melcher**. So you lost three?

Mr. **Williamson**. We lost three, plus the night manager, data coordinator, and medical secretary.

Senator **Melcher**. How many patients do you treat or counsel in a year?

Mr. **Williamson**. We can take a maximum of 50, but we have not been up to 50 yet. We had 182 residents go through last year. It is a 45-day long-term treatment.

Senator **Melcher**. You can have 50 at one time?

Mr. **Williamson**. A maximum of 50. But with this cut, we won't be able to; that will drop us down to a maximum of 20.

Senator **Melcher**. Now, where do you get these people?

Mr. **Williamson**. From the seven reservations out of Montana.

Senator **Melcher**. In this area?

Mr. **Williamson**. From this area and from the Billings area, plus the urban areas. We get quite a few from the urban areas.

Senator **Melcher**. Earlier Matt Pilcher from the Winnebago Tribe said 90 of their 1,300-odd people that were treated for a 30-day period were from the Crow and the Northern Cheyenne Tribe. Were you in operation during that time?

Mr. **Williamson**. Yes, we were in operation. We have been operating since 1972.

Senator **Melcher**. Are you connected with the VA hospital there?

Mr. **Williamson**. We rent from the VA. We are not incorporated with them.

Senator **Melcher**. There is no need to be a veteran?

Mr. **Williamson**. No, no.

Senator **Melcher**. But the maximum would be, if you were at full staff, 50 at one time and be a 40-day treatment?

Mr. **Williamson**. Forty-five.

Senator **Melcher**. I mean 45-day treatment. And now, you think the maximum would be only 20?

Mr. **Williamson**. Twenty—15 to 20.

Ms. **Woodenlegs**. IHS's recommendation is 15.

Senator **Melcher**. Is there a need for the full 50?

Mr. **Williamson**. I think there is a need for probably 40 at this time of the year.

Senator **Melcher**. Thank you all, very much.

Henry Real Bird, I don't see him here. Is he present?

This concludes our panels. We have had to take a lot of the testimony as written, without the oral, but I believe we have a very good cross-section from these two areas of what we should be seeking to do with Indian health care, ranging from problems that have been identified, and statements by several different witnesses, and the very drastic reduction in health care personnel.

Several have testified, whether it is on reservation or urban, that alcoholism is the No. 1 health problem with Indian people. Several mentioned the alcoholism program should be a line item, in order to assure the priority that it should be given.

We have had testimony from several tribes indicating the remoteness and isolation that Indian people experience in regard to health care.

Earl Old Person, very dramatically stated what all of us, I believe, agree to, and that is that health care cannot be postponed and budget cuts, as an attempt to postpone health care, solve no problem at all.

Running through all this testimony has been the recommendation that when budget cuts are necessary, they be absorbed in the administrative end of it, rather than in the actual delivery of health care, to save people on the reservation or off the reservation. Also, the question of whether or not the budget cuts are interfering with preventive health care.

I think, all in all, we have assembled from the witnesses that appeared, and I am sure from the written testimony which we have not had a chance to peruse yet, a very fine delineation of problems. It is not fine, in terms of reassuring to myself or to the committee, that we are doing the best that we can, or should be doing, with the health care dollars that are available. So it is sad on that side.

We have a little over 40 minutes, perhaps 45, to hear from the Indian Health Service people. Dr. Joseph Exendine, Acting Director of Indian Health Service, is here. He will be accompanied by the area directors and the finance officer of the Billings area. Is the area director for Indian Health Service here from the Aberdeen?

Ms. **Steele.** Yes, here.

Senator **Melcher.** You are finance officer from Aberdeen office, also?

Ms. **Steele.** Yes.

Senator **Melcher.** At this point, we will submit for the record the community health representative program survey and the need for health services from the Omaha Tribe.

[The material follows. Testimony resumes on p. 293.]

COMMUNITY HEALTH REPRESENTATIVE PROGRAM REDUCTION

FISCAL YEAR 1982

A Paper Presenting the Justification
for Sustaining the Current Level
in the Aberdeen Area

Presented to the Director, Indian Health Service

From : Indian Representatives
Aberdeen Area
November 1981

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I. INTRODUCTION:

The Fiscal Year 1982 Indian Health Service budget will result in a reduction in the CHR Program of approximately 18% from FY 1981. The CHR Program has over the past thirteen years become an integral and vital part of the Indian Health Service delivery system. The Indian people now depend on and trust the CHR's as the first and most readily available health provider. This paper strongly requests that the reductions required by these budget cuts be taken from other Areas rather than from Aberdeen. This request is based on facts and conditions that exist in the Area and presented in III. below.

With respect to these cuts, below is a quotation from the House Congressional Record dated November 5, 1981, which gives specific direction to the Indian Health Service managers:

> "The managers agree that the reduction in the Community Health Representatives program should be directed at those Areas which have higher concentrations of health personnel in clinics or hospitals; or programs which have been evaluated and found to be less effective or not in compliance with program regulations. The Indian Health Service is directed to report to the Appropriations Committees the proportions of reduction which represent generalists and the proportion representing specialists."

We wish to further emphasize that this is not just a selfish request and urge that after your review Indian Health Service Management will have cause for such action and not apply the cuts with an across the board percentage.

II. FY 1982 PROPOSED BUDGET AND ANTICIPATED REDUCTION

The proposed CHR budget was $39,083,000. This was adjusted in Joint Conference Committee and is presented in the final Bill at $30,000,000, or a reduction of $9,083,000. The FY 1981 budget was $36,295,000 and, therefore, the reduction will be approximately 18%. This would cause a loss of over 50 CHR jobs, and push the Aberdeen Area even further behind the other Areas.

III. HEALTH AND RELATED PROBLEMS IN THE ABERDEEN AREA COMPARED TO OTHERS.

A. TUBERCULOSIS AND OTHER STATISTICS

Control of tuberculosis and other communicable diseases remains a critical community health need in the Aberdeen Area. Tuberculosis new case rates for the Aberdeen Area are decidedly the highest in all of Indian Health Service and are almost double the Indian Health Service average. Control of tuberculosis remains a significant challenge due to the insiduous nature of the disease, prolonged length of the time required for treatment, and the inability of health care providers to modify treatment protocols to mesh with individual beliefs and customs. The success of efforts to control tuberculosis in the Aberdeen Area are contingent upon consistent followup, monitoring and health education provided to clients between episodic visits to health care providers in the clinic or hospital setting. Involvement of CHR's in this process is seen as critical. As knowledgeable members of the community and under professional guidance, CHR's have demonstrated success and achieved results in assisting with patient compliance and contact investigation on numerous occasions when others have failed. Budget cuts which impact adversely upon CHR staffing in the Aberdeen Area will probably result in an increase in tuberculosis case rates at a time when its prevention and control should be of primary concern.

Further, the IHS morbidity index values for 1981 places the Aberdeen Area at 33%. Infant deaths in 1977 (the latest report available to us) are at 30.2% compared to Oklahoma 13.5%, Tucson 22.9%, USET 21.9%, Alaska 17.6%. At rates per 100,000 population for the fifteen leading causes of death, the Aberdeen Area is the highest with 1,135.6, Oklahoma 683.6, Tucson 837.7, USET 662.7, Alaska 696.5, Navajo 613.8.

B. ECONOMIC, ROADS, TRANSPORTATION, CULTURAL PATTERNS

The Aberdeen Area comprises fifteen separate tribes, three urban centers, and the Trenton-Williston Indian Service Area. The Aberdeen Area covers the states of North and South Dakota, Iowa, and Nebraska.

The Indian Tribes are located on original Reservations set aside by Treaty negotitions and are among the most ecomomically depressed in the nation. There are few natural resources, unlike reservations with minerals, timber, with and other value income resources. Aberdeen Area Tribal resource incomes are very limited.

Consequently, no major industrial development has occurred. The Tribes past economy was based on Federally funded manpower programs. The total unemployment is approximately 70% and will rise as the major impact of cutbacks are felt and seasonal work has ended.

This impact is being felt in the community in the purchasing power of the families. Tribal members do not earn large per annum salaries and are generally on the minimum wage scale. Their purchasing power is used for food and subsistence. Nutrition is an underlying major health problem. Alcoholism, Diabetes, and Obesity are directly affected by nutrition. Hopelessness derived from lack of employment and earning power contributes to the consumption of alcohol. Severe winters and extended number of months in a given year that are "cold" create an energy crisis need. All contribute to desperate economic conditions.

Transportation and Roads are a major contributing factors to access to health care. Most Indian families in the Aberdeen Area do not own the newer compact cars, being forced to purchase the older "gas guzzler" type which fits their incomes. These vehicles (if a family owns one) are non-starters in winter, and many times unable to make a reliable, safe trip to a health destination. Roads on reservations are poor, many are still dirt and/or sparse gravel surfaced.

These factors severely impact the health care delivery system in the Aberdeen Area.

Aberdeen Area Tribes are traditional and isolated from mainstream activities. Their concept of time, work, and savings remains traditional. Their cultural values are deep and impact their daily lives.

They are involved in various types of traditionalism in healing practices. The Indian Health Service's unstable personnel system in health care and misunderstanding of the Native healing practices tend to discredit them. These Tribes' practice Uwepi, Sweat Lodge, and Pipe Ceremonies. Herbalists are active. Suspicion of "white" medicine, which does not provide a holistic approach, remains. CHR's are the interface for the Indian Health Service and the traditional Indians of our Area. Language continues to be a major barrier to health care.

C. GEOGRAPHICAL ISOLATION AND CLIMATE

Rservation areas are scattered, divided, and spread out with the majority of people living in grassroot communities. CHR's have to travel 40 to 260 miles to get patients to health facilities. Roads are constantly in need of repair. There are no commercial buslines, airlines, or railroads serving the reservation. Only 40% of the Indian population households own their own cars. There is presently little or no industry on these reservations.

Climate - Due to cold hard winters and rainy conditions during the Spring, at least seven months of the year poses conditions not conducive to safe transportation. Temperatures vary to extremes in these areas, lows of -46° to highs of 112°.

D. LACK OF MODERN MEDICAL FACILITIES

While other Areas, including Oklahoma, USET, Albuquerque, Alaska, Phoenix, and Bemidji have enjoyed the construction and staffing of new IHS hospitals and health centers, the Aberdeen Area has been left out. Perhaps this is due to better and more effective politics in other Areas.

For whatever reason, antiquated facilities and equipment are a deterent to recruitment and retention of good qualified health professionals. The lack of adequate numbers of health professionals puts an even greater burden on the CHR's. The newest hospital in Aberdeen is Belcourt which was constructed seventeen years ago. Facilities such as those at Rosebud, Pine Ridge, Sisseton, Winnebago, are a disgrace in terms of modern 1982 level health care facilities.

E. REDUCTION IN HEALTH PROFESSIONALS

The Aberdeen Area is considered the "Siberia of the Indian Health Service" and has one-hundred vacancies as of this date, with 32 of those being in nursing and 8 in the medical staffing. The Tribes have been involved in recruitment and retention programs, but with the isolation, severe weather conditions, and antiquated facilities and equipment, it is most difficult to entice health professionals to the Area and keep them. With the current freeze Indian Health Service personnel are accepting positions and transferring to more attractive Areas, i.e., USET, Albuquerque, Oklahoma, Tucson, Phoenix. The Communicable Disease Center has for years past assigned a professional person to the Aberdeen Area. This position was successful in monitoring and managing the Area program for controlling communicable diseases: Tuberculosis, Venereal Disease, Hepatitis, Diphtheria, Measles, Mumps, etc. The position has now been lost to the Aberdeen Area due to a cutback. The loss again places a heavier load on the Public Health Nurses and the CHR's. Preventive health is the truly effective health measure. "An ounce of prevention is worth a pound of cure."

F. REDUCTIONS IN THE ENVIRONMENTAL HEALTH , HEALTH EDUCATION, AND AMBULANCE BUDGETS

The impact of the Budget cuts in Health Education, Environmental Health, and the EMS Programs besides the other community services programs not funded through Indian Health Service will force the CHR's to fill the void and place a heavier workload on them with less manpower. CHR's on many reservations are now carrying out the full responsibilities for safe water, including fluoridation and chlorination. They also are driving ambulances and functioning as the local health education specialist.

SUMMARY

The overall health status of Indian people has been improved and most notably started rising with the implementation of the Community Health Representative Program. CHR's have grown from inexperienced fledglings and have overcome the skepticism that goes with change, and now provide the nucleus of health workers who are responsive to all the health needs of Indian people. Indian Health Service is dependent upon the services CHR's provide.

The Aberdeen Area CHR's have provided leadership for the entire Indian Nation. We hope Indian Health Service will meet the challenge we place before you and take into consideration the grave need we have in comparison to the other Areas.

THE NEED FOR HEALTH SERVICES OF THE OMAHA TRIBE OF NEBRASKA

The Omaha Tribe of Nebraska Reservation, by treaty of 1854, is located in North Eastern Nebraska and covers over 2/3 of Thurston County, and is adjacent to the Winnebago Tribe's Reservation, covering 1/3 of Thurston County.

Our population is numbered at 2,200 on Reservation.

Unemployment is at a 70% rate.

Weather is a factor in considering access to health care as well as road conditions, which are poor in the best of weather. Seasons are long for Winter cold months, usually from October to mid-April.

Homes are widely scattered over the Reservation, many with dirt roads.

The proposed budget cuts for Indian Health Service will be disasterous for Indian Tribes, as a whole. More specifically to the Reservation areas, where our basic economy was established on Federal Work Programs.

The Omaha Tribe under a 93-638 (Indian Self-Determination) Contract with Indian Health Service, Aberdeen Area, provides Ambulatory Patient Care Services to 2,200 persons living on the Omaha Reservation, and approximately 800 near the Reservation, who are eligible for services.
The Tribe operates a 25-bed Nursing Home. In-patient care is provided at the Omaha-Winnebago Service Unit, as well as night emergency services. All major surgical and acute care is contracted out to the private sector.

While health conditions have improved over the years, the major health changes occurred with the advent of the Community Health Representative Program in 1969.

The C.H.R.'s have provided a communication service to the Patients and health care resources. Interpreting, monitoring and motivating patients for compliance. The best medical staff in the world cannot treat a patient successfully without communicating to bring about compliance. The C.H.R.'s have been taught to provide essential para-professional services, which frees up the time of professional staff, who are difficult to recruit in sufficient numbers for our hospitals and clinics.

C.H.R.'s do provide essential transportation to our contract resources. Our people would not receive the medical attention they need, since most cannot provide their own transportation, and utilization of contract resources is a part of the Indian Health Service System nation-wide.

Indian Health cannot provide adequate services due to funds, lack of staff and equipment and Contract Services appears to be the less costlier method of providing certain health care. No Indian Health Service hospital in the Aberdeen Area is provided with the types of diagnostic and treatment equipment used in today's urban hospitals. Our renal dialysis Patients are transported 150 miles, 3 times a week in all weather, and many times patients are being sent to widely spaced locations each week, due to availability of machines.

Of great concern is the increase in morbidity and mortality among our Tribal people.

An increase in tuberculosis, new cases has occured.

Infant mortality is higher among the Indian people in Nebraska, as well as being significantly higher then U.S. all races.

Diabetes is a disease afflicting 50% of our population, ¼ of the visits to I.H.S. clinics and hospitals are either directly or indirectly traced to diabetes. The type of diabetes found among our people can be prevented by special programs and emphasis on Nutrition. Yet only 5 special programs were mandated by Congress most recently, and now may be absorbed into the I.H.S. System without proper technical supervision. 60% of the blind on Indian Reservations are attributed to Diabetes, 50% of all dialysis patients and 75% of all amputations are caused by undiagnosed and/or untreated diabetes. Partly due to lack of compliance and motivation of the patient and due to lack of adequate personnel and interest of medical staff. Programs as this special mandated program should not be cut from the budget.

Alcoholism is afflicting a major portion of our population with catastrophic impact on our contract health dollars, yet no significant efforts are made to provide services in the area of Drug Abuse and Mental Health, and if provided, are inadequate.

Accidents, violence, and poisonings are major causes of morbidity and mortality, directly attributed to alcoholism.

Indian People gave up valuable lands inexchange for certain treaty obligations. This should be a major factor in identifying Indian Health Care as an entitlement program.

Too many dollars have been spent in bringing Indian people to a level of health care compatible with that of U.S. as a whole. Cutting existing services will only create needless waste of human life, and delay in attaining this goal.

We urge that any cut-backs contempolated not be in the area of direct services or staff to provide that service.

RESPECTFULLY SUBMITTED:

Matthew Sheridan, Health Planner
FOR OMAHA TRIBE OF NEBRASKA

Senator MELCHER. Dr. Exendine.

STATEMENT OF DR. JOSEPH N. EXENDINE, ACTING DIRECTOR, INDIAN HEALTH SERVICE, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY BYRON NIELSON, FINANCE OFFICER, BILLINGS AREA; BILL WASEM, FINANCE OFFICER, ABERDEEN AREA; ELEANORE ROBERTSON, AREA DIRECTOR, ABERDEEN AREA; AND JIM SMITH, AREA DIRECTOR, BILLINGS AREA

Dr. EXENDINE. Mr. Chairman, as you are well aware, I am the Acting Director of the Indian Health Service. Let me introduce the people at the table here. On my left is Byron Nielson, who is the Finance Officer for the Billings area. Next to him is Bill Wasem, who is the Finance Officer from the Aberdeen area. And on my immediate left is Eleanore Robertson, who is the area director for the Aberdeen area. And on my right is Mr. Jim Smith, the area director for the Billings area. Since you are under a time constraint, why don't I summarize the opening statement.

Senator MELCHER. Fine.

Dr. EXENDINE. I might point out that there are other staff members here for technical questions, if needed.

Senator MELCHER. That is fine. Thank you.

Dr. EXENDINE. As you are much aware, we do provide medical care for about 865,000 American Indians and Alaska Natives and approximately 300,000 urban Indians. Of the 41 Indian urban projects that we have, 8 are located in your area. The budget before you, fiscal year 1982, is for a $646.8 million budget, a $42.9 million decrease from the previous year. The fiscal year 1982 budget has $599.7 million for Indian Health Services and $47.1 million for Indian Health facilities.

Instead of going through the list of numbers that is on the second page let me just point out very clearly that over the years, direct health care has been a No. 1 priority within Indian Health Service, and it is still maintained as No. 1.

The 1982 budget provides funding to operate new facilities and to staff those facilities and to serve three new tribes that have been federally recognized.

The 1982 budget that has been presented will actually give us the possibility to continue basic programs that are under the continuing resolution. I would like to point out that we have not seen any of the language in the continuing resolution nor have we seen any of the specific language in the bill that is before the President.

With that summary, Mr. Chairman, I would be more than happy to answer any of the questions that you may have.

Senator MELCHER. We expect the President to sign H.R. 4035, I believe that is the right number, for the appropriations for Indian Health Service. Have you not seen the bill and the report?

Dr. EXENDINE. No, we have not seen the report. I have some numbers. We have some numbers, which actually are on the second page.

Senator MELCHER. Are you not allowed to see it before it is signed?

Dr. EXENDINE. We negotiate; but we do not see it.

Senator MELCHER. Well, you know, those reports are available. The record is available.

Dr. **Exendine.** Right.

Senator **Melcher.** The whole series of steps are available in the Congressional Record.

Dr. **Exendine.** Sir, it is my understanding, as of this morning, we do have a copy of it back in headquarters.

Senator **Melcher.** Was the administration, meaning the White House, the OMB, President Reagan, saying do not look at it until the President decides whether he is going to sign it or not?

Dr. **Exendine.** No, we have an opportunity to look at it. It was not available.

Senator **Melcher.** Does he not ask for your comments? Surely if he was not going to sign it, would he not ask you for your comments? You know, he has until December 23 to sign it or veto it. That is the day after tomorrow.

Dr. **Exendine.** We have the opportunity to, through the process, to appeal.

Senator **Melcher.** You haven't been consulted, so that must mean that what Senator McClure and everyone else in the Senate, including myself has thought about it is true; they feel he is going to sign it; is that correct?

Dr. **Exendine.** Early in the process we did have the opportunity to appeal it, and it was my understanding it probably would be signed.

Senator **Melcher.** I am confused about the deferrals. To your knowledge, is Stockman running the show there on Indian health? What is going on? What business were those deferrals? What are you supposed to do? Earl Old Person testified, stating it quite well; you cannot postpone health care. What were you supposed to do with those deferrals?

Dr. **Exendine.** The instructions, the guidance we received from OMB, actually permitted us to operate, as you well know, at the $551 million level.

Senator **Melcher.** What did it mean to you? What happened then, when you got that little slip of paper?

Dr. **Exendine.** It means, actually, we were cut from the continuing resolution from a $606 million budget. We operated at the 90 percent level, 10 percent less than last year.

Senator **Melcher.** I can understand the dollar figure, but what did it actually mean in terms of health care?

Dr. **Exendine.** In terms of health care, the thing that probably had the most impact was that earlier we were under a freeze for filling positions. We had to curtail, drastically, traveling and training. We had to cut down very drastically on the purchases of supplies over the counter and those types of things.

I would like to point out, under no circumstances, to my knowledge, did we absolutely stop providing services. We may have deviated somewhat. For example, when we could not hire nurses, as I heard earlier in the testimony, or could not provide some type of care, we always went out on contract with it to make some provision that the type of care was still there.

Senator **Melcher.** Several have testified that community services were reduced. Was that part of it?

Dr. **Exendine.** Yes, it was. Probably, in reference to that, it came under the freeze that was imposed upon us for hiring any individuals.

Senator **Melcher.** What about those who were on the payroll?

Dr. Exendine. No, it should not have.

Senator Melcher. Should not have been reduced?

Dr. Exendine. No, we were not reduced any positions at all. We were not provided the opportunity to put on or hire additional persons once the vacancy was there. I would like to point out, however, that recently the Secretary, in one of our appeals to him, gave us permission to go ahead and fill some critical positions, which we had appealed to him earlier.

Senator Melcher. Well, Donavan Archibald, on behalf of the Fort Belknap tribes, said there was a 75-percent reduction in personnel as far as the tribal administrative part of it; health care. What would bring that about?

Dr. Exendine. I really cannot answer that. The only thing I can probably relate to that is the fact that since September 1, as I indicated, we had to operate at the 90-percent level, and because of the budget structure, they absorbed the 10 percent just like all the rest of us did. We operated at a 10-percent across-the-board reduction.

Senator Melcher. You said September 1?

Dr. Exendine. Since September 1. I am sorry, since October 1.

Senator Melcher. Would that account for a $70,000 reduction that you mentioned?

Dr. Exendine. I am not familiar with their exact budget.

Senator Melcher. Mr. Smith, do you know?

Mr. Exendine. I think it was reduced 10 percent from whatever their budget would be.

Senator Melcher. Mr. Smith, do you know?

Mr. Smith. This came about, Senator, last year. Over the past few years, we have been funding tribal health departments out of what at that time was called 638 dollars, which was a limited amount of dollars. This year we were surprised as to what we could expect in terms of dollar figures. Because the dollar figure in total that was available would not fund all the tribal health departments in terms of what they had come in for. We went back to the tribes and said, based on that, we will have to take that amount of dollars and make it available for all tribes on some sort of either per capita or just a straight division, so much per tribe. That was the reason for the reduction.

Senator Melcher. Where did you get these 638 dollars? From what category did that come?

Mr. Smith. It was previously a separate budget category.

Senator Melcher. Ten percent across the board?

Dr. Exendine. Mr. Chairman, let me respond to that. Originally it was an individual subactivity within our program, and 2 years ago we started a process of changing that into our hospital and health clinics budget for the simple reason that any time that we experienced a cost increase, the tribal employees would share in the same thing, and of course, when we get a reduction, they would also share in the same reduction.

But we took those programs and moved them into the hospital and health clinics category. Some of them. Some of them we kept in the preventive health programs.

Senator Melcher. The fact that you applied the cut, while it might not have any affect on the employee of permanent status with a civil service rating, it meant that the cuts then would come out of these people who were working for the tribes, because they had no civil service rating, is that not true? All those with civil service ratings would not be in that position if you had a hiring freeze. When you absorbed the money, you in effect, passed it right down to the tribe and the reservation, did you not?

Dr. **Exendine.** It was really based on dollars, at 10 percent.

Senator **Melcher.** You did not reduce 10 percent of the dollars spent in the area office for civil service employees, did you?

Dr. **Exendine.** Yes. We took a 10 percent across the board. We took the same types of lapses in filling vacancies right along with the tribes.

Senator **Melcher.** Does that amount to 10 percent in a 2-month period?

Dr. **Exendine.** I would hazard to say it would be much more, much greater. I can point out the fact that earlier the CHR program and the urban programs were zeroed out. We were supposed to zero them out October 1.

Senator **Melcher.** That was not a 10 percent cut.

Dr. **Exendine.** Well, we were given the option to take the 10 percent and spread it over all our budget, and I personally took the prerogative to continue the CHR programs and the urban programs and take the absorptions out of travel, training, and everything else, in order to keep the CHR programs and the urban programs continuing. I took it overall, so they could continue, instead of zeroing them out.

Senator **Melcher.** I am glad you did that. But it just does not balance out when we hear of a 75-percent reduction in the Community Services program. It just does not agree with the 10 percent.

Dr. **Exendine.** Well, like I say, I can not specifically address that.

Mr. **Smith.** Well, you have to go back 2 years to followthrough what happens. We have 638 dollars. Last year we got some supplemental money in the amount of about $130,000 or $140,000, I think, to help offset that increased cost to those programs. The programs grew, the amount of moneys in terms of recurring dollars did not grow. So this year we were advised we would not be getting those additional supplemental dollars and had to plan the programs based on the base amount of dollars that we had in the budget, which at that time I think was—I am not even sure of the dollar figure. We had to come back and plan those programs and said we could fund them only within that specified dollar amount and not consider any supplemental dollars.

Senator **Melcher.** That is all very well, but I do not think it serves our purpose here to be describing the effect of a 10-percent cut for a 2-month period as not resulting, on the reservation level in at least CHR, and this one tribe's case, a reduction of 75 percent, and as a direct result, where the budget cuts were going to be. It could be, you could say, well, it can be straightened out later, we can back off at 638 or we can fund them differently, or what have you. But, I think at this point in time, we ought to realize where we are, and where we are is in most of these tribes' case, the Community Service part of it. Part of the program has not been reduced 10 percent. It has been reduced anywhere from 30 to 75 percent or perhaps even 80.

Dr. EXENDINE. Mr. Chairman, with your permission we would like to have an opportunity to look into that and present you with a report on that particular case.

Senator MELCHER. Well, I think this is the part in which we are interested. I think most of us on the committee have become convinced that CHR is very good, and should be funded up to the level that we anticipated would be available for all of fiscal year 1981 and hopefully for virtually all of 1982, or very close to the same level.

The Rocky Boy Reservation indicated that they had run out of contract care dollars. Are you aware of that? Maybe I better ask Mr. Smith.

Mr. SMITH. I think run out is a little—not the exact terminology. All of the service units on the reservations in this area are presently operating on an emergency only basis, and have been basically since the first of the year.

Senator MELCHER. Since the first of what?

Mr. SMITH. Sir?

Senator MELCHER. The first of this calendar year?

Mr. SMITH. Since we went on emergency basis October 1.

Senator MELCHER. The first day of the fiscal year?

Mr. SMITH. Right. And this is true at all reservations. We are operating emergency only throughout the area, and only providing that which is necessary for preservation of life and limb.

Senator MELCHER. Since there is $107 million available for this period of time—no, it would not be that much. For contract care under the continuing resolution, there is $107 million available. That was the amount that was agreed to by the President. So, since October 1, why was not contract care available on that basis?

Dr. EXENDINE. Mr. Chairman, I would ask Bryon Nielson to perhaps answer that question.

Mr. NIELSON. We were operating on the President's budget level which was $551 million. We were not allowed to operate at the continuing resolution level, which was either the house level or the 1981 level, whichever was lower. But then the President submitted deferrals which forced us to operate on a level lower than that, which was the $551 million level. That is presently 10 percent below 1981. That is—we have been operating on that level——

Senator MELCHER. What dollar figure do you want to stay 10 percent below?

Mr. NIELSON. I am talking about fiscal year 1982; we were operating 10 percent below.

Senator MELCHER. Well, the President's figure was $107,465,000. Now, you want to take 10 percent of that amount?

Mr. NIELSON. That is the national level. The Billings level was $14,461,000. Ten percent below that would be what our level was.

Senator MELCHER. Why was that money not available, 10 percent off of $14 million?

Mr. NIELSON. That money was available, except we experienced something like a 17- or 18-percent inflation rate in the cost of medical services, contract medical services, and we were operating at 10 percent below what we had the previous year.

Senator MELCHER. What are you going to call an emergency?

Dr. **Exendine.** Any type of accident, primary accident, emergencies, things along that line. Auto accidents would probably be the primary type of emergency.

Senator **Melcher.** Since you had $14 million available in this area for contract care, less 10 percent, why would there not be money available for more than automobile accidents and falling off a horse or whatever else you want to categorize as an emergency for contract care?

Dr. **Exendine.** Let me attempt to explain that. As you well know, money is apportioned quarterly, and we do give directions to the areas that they have to live within a certain percentage of that by quarter, otherwise they would use up their entire budget——

Senator **Melcher.** Twenty-five percent.

Dr. **Exendine.** Yes. They would use up their entire budget say in half a year and would be completely without any dollars. So as a result, all areas are under the same directives. They do have to use some drastic measures on some occasions where one auto accident may take $20,000 or $30,000 out of their immediate budget. So there has to be some priorities.

Senator **Melcher.** I am going to use Rocky Boy as an example. I would imagine if a youngster needed his tonsils out and recommended that he have his tonsils out, that that patient would go to Havre, to the hospital; is that right, to have the tonsils out?

Mr. **Smith.** Probably would.

Senator **Melcher.** Probably. Well, I guess the point of my question is, they are not going to do it there at the clinic, are they? They are going to send him to a hospital. So probably, it would be Havre. That is contract care. Is that an emergency?

Dr. **Exendine.** No. That is elective surgery. And what we do with that——

Senator **Melcher.** Well, I do not think we are saving any money—I cannot imagine anyone being told he must have his tonsils out who would want to defer it.

Dr. **Exendine.** What we generally do in this case, as the quarters go along, then if there are sufficient dollars in any year, we do perform the elective surgery. We try to save our initial dollars for all types of emergency cases.

Senator **Melcher.** Well, if the doctor says this youngster's tonsils should come out, what good does it do to defer it?

Dr. **Exendine.** If he thinks that it is absolutely necessary for that child to have his tonsils taken out, then that child is referred to have his tonsils taken out. It is the judgment of the physician.

Senator **Melcher.** Can you assure me that all necessary dollars are available for Rocky Boy or any of the rest of the reservations?

Dr. **Exendine.** No; there are not enough dollars for any of them. I think, as Mr. Nielson pointed out, over the last several years medical care has increased around 20-some-odd percent, anywhere from 17 to 30 percent, and our cost increases have minimally been held to about 9 or 10 percent. So over the years, we have gotten behind, and have not kept up with the inflation rate.

Senator **Melcher.** Let's clear up one point. Part of the testimony we heard today from the Berthold Tribes was that the most recent increase in cost for hospital care under contract care was 2.5 percent. I suspect that was for the last fiscal year. Is that true, or is that general in most hospitals?

Dr. EXENDINE. You mean in the increase in costs?

Senator MELCHER. 2.5 percent.

Dr. EXENDINE. No; I think most of the costs have been running—like I indicated, 15- to 25-percent increase.

Mr. NIELSON. We were projecting an 18-percent cost increase over last year in contract health care.

Senator MELCHER. What was it fiscal year 1981?

Mr. NIELSON. The previous year, I think it was something around 15 to 16 percent.

Dr. EXENDINE. We are allowed to put into our budget an average of about a 9-percent increase rate for contract health care. It averages out right around 9 percent.

Senator MELCHER. Well, am I correct that the Reagan budget was the same for fiscal 1982 as the amount appropriated in fiscal 1981?

Dr. EXENDINE. No; I think it would be, Mr. Chairman, on the Contract Health Care. I think basically we ended up with about $110 million, a slight increase over the $107 million. It is a plus $2.9 million. I do not have the calculation on the percentage.

Senator MELCHER. That is what Congress finally resolved?

Dr. EXENDINE. That is right. Actually what happened is that in the conference they came out with $115 million and as you well know, they cut that. So it ended up with $110 million.

Senator MELCHER. I believe the figure that the President submitted for budget purposes was $107 million, same as it was last year in the actual appropriation.

Dr. EXENDINE. Yes.

Senator MELCHER. Now, what about most of these people whom we have heard from today? They said that alcoholism is the No. 1 problem, but the alcoholism programs are ranging quite low. Where are these dollars supposed to come from if that is the No. 1 health problem?

Dr. EXENDINE. Let me back up a little bit. We first started taking the alcoholism programs over in 1978. They are grant programs. And I think in both House and Senate testimony we agreed to take them at the dollars that they were funded under NIAAA, another agency within the department. Once they were transferred to us, it has been the policy of the department that all grant programs would not experience any of the cost increases, because they are grant programs. I would like to point out that Indian Health Service each year put in inflationary cost increases for these programs and in some places they have been denied.

In all cases, they have been denied. In some instances, we have put some of our own money in there when we felt like the inadequacies were there.

It is my understanding that at no time has this administration nor the Congress ever talked about eliminating the alcoholism projects. They have been in there since we submitted our first submission request over a year ago, and to my knowledge no one, again in the administration, in Congress, OMB, or any place else, has made any indication that the alcoholism projects are going to be eliminated. They will experience a cut right along with the rest of the programs. But, again, like I pointed out, they have not had any inflationary cost increases over the years because of the departmental policy that grant programs transferred over to us will not get any increases in spite of the fact that some of them are under contract.

Senator **Melcher.** Do you feel alcoholism is the No. 1 health program?

Mr. **Exendine.** Yes; it is.

Senator **Melcher.** And, that it should have a higher priority?

Dr. **Exendine.** I certainly think so.

Senator **Melcher.** Is there some reason why it is impossible that financial support for area and tribal health boards cannot be funded out of the program management budget category?

Dr. **Exendine.** Presently what we are doing, as I mentioned earlier, and I am not really talking about the CHR programs in this instance here, but I am talking about tribal programs per se where they take over some aspect of our program. We have transferred them again; because of our budget structure that we started 2 years ago they are now included in our clinical services budget. As I pointed out earlier, any increases, or any decreases, they will experience the same as we do.

Senator **Melcher.** What category would that be in?

Dr. **Exendine.** Actually, I would have to show you——

Senator **Melcher.** Would it be in clinical services?

Dr. **Exendine.** Yes; it is in clinical or preventive services. All the programs that the tribes take over, other than the CHR programs, are in our clinical or preventive services budget, and it is under a category where we label medical services under grants and contracts, excluding CHR's. But it is under the programs, again, medical services under grants and contracts.

Any time we go in for mandatories or any kind of inflationary increases, they now are included.

Senator **Melcher.** But you do not believe they should come out of program management per se?

Dr. **Exendine.** I think continuing them in hospital/clinics is much more advantageous than coming under program management. Over the last 3 years we have had a $7 million reduction in program management. Since we have put high priorities in clinical services, and they are now in clinical services, I think they will maintain a better chance of surviving at an adequate level than in program management, since as I indicated, we have taken quite a cut over the last several years in program management.

Senator **Melcher.** The clinical service end of the budget stayed a little bit higher percentagewise?

Dr. **Exendine.** Right. As I indicated here, that is our No. 1 priority, and we try to maintain that above all costs.

Senator **Melcher.** What about what the Winnebago Tribe described, and I suspect we have other examples very similar to that, in submitted written testimony, that they would not hire the filling of four nursing vacancies?

Dr. **Exendine.** Earlier in the year we were under what you call a two-for-one hiring freeze. Where two people left the program, we could hire one. We had three major categories. Then starting October 1, we were under a complete personnel freeze, and we could not hire any individuals at all. However, as I pointed out earlier, we solicited from the areas all the critical positions that were needed and appealed this to the Secretary and within, I would say in the last couple of weeks, 2 weeks ago, we were given authorization to fill those critical positions.

Senator **Melcher**. That is a critical position, is it not?

Dr. **Exendine**. Absolutely, yes, sir.

Senator **Melcher**. What about those three counselors that were to be eliminated at the treatment center that rents a facility from the VA Hospital?

Dr. **Exendine**. They are not our Federal positions. I could only say they would come under that 10 percent cut. I really cannot relate to that. They are not our Federal positions. So I could not really say.

Senator **Melcher**. That was a much bigger cut than 10 percent, was it not? An $80,000 cut. It referred to alcoholism. For this bill it is the alcoholism treatment program, the 45-day treatment that we were discussing with that last panel.

Mr. **Smith**. In that case, Senator, what we had is the alcoholism program itself as being funded under a grant of $262,000 from NIAAA. We had, through IHS, the Contract Health Service had supplemented that program. This year, because of the cutback in the amount of moneys available under Contract Health, and the need to just provide for basic life and death situations, we did find it necessary to make a reduction in that program. Not one that we wanted to do, but one that in order to put those types of dollars like at Rocky Boy and other reservations to take care of the accidents, the emergency-type services.

Senator **Melcher**. Well, they are not anywhere near the level they were funded under NIAAA?

Mr. **Smith**. They are still getting the NIAAA funding of $262,000. We were providing a supplemental amount over and above that. So there is still $262,000 going into the program.

Senator **Melcher**. Well, recurring all through this discussion today, and the testimony that we have received, was the recommendation that more of the cuts be absorbed at the administrative level. Now, when you say that we have had program management cut from $54 million down to $48 million—if that is the financial figure in the bill—and since contract care, admittedly, Dr. Exendine, is not going to meet all of the needs for actual patient care, what are you going to do about that?

Dr. **Exendine**. Mr. Chairman, over the last several years we have taken drastic cuts in program management. We have cut approximately $7 million out of it. I would like to point out that we have taken some drastic steps. I think, earlier, I heard here some question about our research and training center and ORD. We are in the process of taking a very serious look at it. We have already taken some drastic measures there. We have already taken a look at the Albuquerque program out West, as I indicated earlier. The figure that is before you is quite misleading, and let me point out the reason that it is.

In headquarters we keep a lot of money. There is no question about it. You indicated there around $54 million down to $48 million. We pay all the utilities in the Indian Health Service from the funds which we retain in headquarters; all the communications; and we pay salaries. We have about 200 employees at headquarters. We pay for all the FTS communications. We pay for what they call SLUC. It covers all the rental expenses for the facilities throughout the country. We maintain what we call a reserve; it is made up of change of station, retention pay for physicians. The reason we keep this large reserve rather than giving it out to the area is they have to actually experience a change of station from an individual say from Aberdeen to Billings or Billings to Phoenix, and once they get the actual experience, we reimburse them rather than giving them the money. But in that reserve that we keep there, at the end of the year, if there is extra money left, then we disburse it to the areas immediately, during the fourth quarter. But that is the reason—we pay a good many of the bills. That is the reason for the large amount of dollars that is shown there.

Senator **MELCHER**. That is in the Washington rental. Let us go down to the area level. You know, it is nothing new, What is going to be the policy in terms of more health care actually delivered and less overhead in the area offices? Mr. Smith, do you want to respond to that first?

Mr. **SMITH**. Well, at this point we figure that the overhead cost of the area office is roughly about 8½ percent of the area budget. The majority of those positions in the area office are those—I will say the administrative-support type. The people who pay the bills, the people who keep the accounting records, the people who purchase supplies, the people who hire other people, et cetera. We have found it, in our opinion, to be more cost effective to centralize those functions in one location. For example, right now if we operated the type of system for accounting and paying bills that the Federal Government prescribes at each facility, we would probably have to have a minimum of 4 to 5 staff members in that function alone.

Senator **MELCHER**. You have more paper work than you need?

Mr. **SMITH**. I guess, but there are always ways if you did not have to make certain reports and stuff, yes.

Senator **MELCHER**. Do you have a series of recommendations to curtail paper work?

Mr. **SMITH**. I think we have gone through that with our headquarters office, in terms of internal reporting and stuff. A couple of years ago we had quite an exhaustive study that I went on in terms of reducing unnecessary reporting, these types of things. That has been done.

Senator **MELCHER**. Was there any reduction in personnel as a result of that?

Mr. **SMITH**. I do not recall if there was a specific reduction of personnel. Here, there was a reduction in terms of paper work. There was a reduction in terms of time, I think, which now is devoted to things that are of greater importance.

Senator **MELCHER**. Well, we have, for instance, the question of the Sandy Rock Sioux where they had two doctors available at one point, I believe it was Eagle Butte. They have 2 doctors available for 4,800 Indian people on the reservation, and 4 clinics where a doctor goes once a week, leaving 1 doctor available at the hospital.

Now, surely when you balance off the need for people to shuffle the paper and fill out forms against the need for the doctors, there is only one conclusion that can be drawn.

Ms. Robertson, what about that?

Ms. **Robertson**. We have two full-time physicians at Eagle Butte, and I wanted to get that straight. Eagle Butte is Cheyenne River and Standing Rock is Fort Yates. Drs. Richard and Virginia Uptegraf have been full-time physicians there for at least 2½ years, and we have been supplementing our physicians staff throughout the Aberdeen area with part-time physicians for the past year. We have had—I do have our chief medical officer here with me, and I am not—Rupert, correct me if I am wrong, I think we have had about 150 part-time physicians rotating through Cheyenne River alone at 2-week intervals, 2 to 4 week stints. That is not satisfactory. That, in no way, provides continuity of care, but we have been faced with recruiting for isolated regions, poor housing. We are 70 miles from Mobridge; about 70 or 80 miles from Bismarck. And I think we have been able to utilize physicians through project USA, at least we have been able to get some part-time physicians. If we keep at least two full-time physicians on, that gives us a core staff.

Senator **Melcher**. Do you have the funds?

Ms. **Robertson**. We have had the funds. We found the funds. We have used the funds, you know. My purpose is to provide medical services to Indian people, and we have done that at all costs, at a terrible toll on the continuity of care. I think the care at times has been minimally satisfactory simply because we have had people for only 2 weeks—you simply do not get continuity and quality care with short-term people.

Dr. **Exendine**. Mr. Chairman, let me add to that. I think over the years recruitment has not really been the major problem. Retention has really been very difficult. For a lot of reasons: Again, social circumstances; the housing; and things along this line. It has been very difficult to retain physicians in isolated areas, and over the years, especially during the draft, the National Health Service Corps, on their payback after they get through, they much prefer to go to the private sector where they make a great deal more money, so as a result, retention has been a problem.

Senator **Melcher**. What do we allow for a doctor's pay? Do we give bonuses?

Dr. **Exendine**. Yes; we do. They start out in the neigborhood of around $35,000 and they will get what you call incentive pay and continuation pay, and it will add anywhere from $5,000 to $15,000 to their pay. Still it is not competitive with the private sector, and, of course, it varies from the length of service they have been in, and things along this line. But starting pay is not equivalent to the private sector.

Senator **Melcher**. Is the starting pay $30,000?

Dr. **Exendine**. I think approximately $35,000.

Senator **Melcher**. Does that include the incentive?

Dr. Exendine. No; it would not include the incentive pay.

Senator Melcher. I am afraid it would not attract, and weigh that against living at Eagle Butte, you said 70 miles from Mobridge. I think the testimony was 85 miles. Which is correct, 70 or 85 miles?

Ms. Robertson. I am corrected, closer to 85 miles.

Senator Melcher. Using that as an example, when it is a question of contract service, or a question of an emergency, if you have only one doctor at the hospital, what happens if that doctor is swamped or sick himself or herself, then that patient is going to have to go to either Mobridge or Rapid City or Belle Fourche or Pierre; is that right?

Ms. Robertson. Yes, that is correct.

Senator Melcher. And, all of them are about the same distance at least. I mean, you could be 40 miles west of Eagle Butte and not be any closer to any hospital than Mobridge, is that not correct?

Ms. Robertson. Right.

Senator Melcher. So, as a matter of fact, you are talking about 120 miles away from a hospital, if the hospital and the doctor is not available at Eagle Butte?

Ms. Robertson. That is correct.

Senator Melcher. It is a very treacherous situation then.

Ms. Robertson. Yes.

Senator Melcher. What do we need to do to correct that, Doctor? More pay?

Dr. Exendine. There are several things that have been discussed over the years since I have been with the Indian Health Service, and I think, of course, pay would naturally be a big incentive.

Senator Melcher. How about housing?

Dr. Exendine. Housing, absolutely.

Senator Melcher. As a matter of fact, having more doctors because no doctor wants to be in a hospital alone, does he?

Dr. Exendine. No; he does not, and it is not a good practice to have him in a hospital alone. My own personal opinion is that there should be a backup staff, again we are talking about at the area office, who can go out to each facility and permit this particular physician to get some R and R. That is worth a million bucks to a person.

Senator Melcher. I think there are several points we agree on, you and I, and I am speaking for the committee. I am sure they agree with us, too. I want to summarize those.

Alcoholism should have a greater priority than it does now in the budget process; more dollars available. We should be paying, and you should have the ability to pay, more for doctors to attract them. Not just talking about young doctors. You would rather attract experienced doctors, would you not?

Dr. Exendine. Yes.

Senator Melcher. That will mean more pay, better housing, and better facilities, and more of it.

Dr. Exendine. Right.

Senator Melcher. How about the hospitals?

Dr. Exendine. Hospitals, I am proud to say right now we either have all of them accredited or certified by the joint commission, or medicare. However, I would like to point out the fact that it will take approximately all our dollars and skills to maintain them either for accreditation or for certification. In many instances some of them, the facilities, are 40 and 50 years old.

Senator **Melcher.** The third point I believe you and I agree on, Doctor, there are not enough funds available as presented for maintaining the programs on the reservation. Now, to maintain them, you could strip your Washington staff or the area staff or something, but how much priority are you going to give that in your recommendations. I understand you are just going to remain active, you are not going to be the chief shotgun after a month or two. But what kind of recommendations will you pass on to the new director that I understand is going to become the director?

Dr. **Exendine.** I think probably what we will do is, again, as we have already done: we have solicited from each one of the areas a planning process, a schedule of plans or recommendations. The reason the central office lets the areas make recommendations is they are closer to the scene, rather than us sit in Washington and say: you should do this and do that. We are in the process of soliciting from the areas the type of recommendations that should be made in the curtailment of the budget.

I have a task force of medical people taking a look at what you would call a health benefit package. I think Ms. Robertson spent the past week on the committee fighting over what should or should not be considered. There are no conclusions, believe me. We are in the process of taking a very careful look at it.

Senator **Melcher.** Did I understand your earlier comments: that you are looking at a reduction in funds available for—what was the facility at Albuquerque?

Dr. **Exendine.** It is not a facility. We have what is labeled as headquarters west or Albuquerque west, and it is much like the R. & D. center that was out in Tucson. Go back in history a little bit. We did close down the training center there, which was costing us a great deal of money.

Senator **Melcher.** At Tucson?

Dr. **Exendine.** Yes, sir. We are now in the process of, for all practical purposes, eliminating the complete operation that is called research and development. We have a somewhat similar situation, but not quite, in Albuquerque, where we do have, for example, our mental health office, our diabetes program there, children's program; we do have some direct primary care programs in that area.

Senator **Melcher.** What will that mean in dollars—$10 million or $20 million?

Dr. **Exendine.** No, sir. What we are really looking at is probably in the neighborhood, I would say, probably $2 million to $3 million. That is a very rough estimate. I am sure I am not accurate on those figures. We are looking at it.

Senator **Melcher.** Well, how will the $4,800,000 medicare, medicaid funds affect primary care?

Dr. **Exendine.** We are hoping to get some clarification from the committees on this, and as indicated in the language, it is to be used for operations. What I hope, and as I interpreted it personally, is that we can take the $5 million offset, and retain 411 people in our facilities, like lab technicians, health records, X-ray technicians, that actually provide us with the ability to maintain accreditation in order for us to collect medicare and medicaid. And as a result, it is my interpretation, hopefully the committees will agree with me, we can take an initial $5 million and retain those individuals and give us the ability to maintain accreditation and certification and that is really what I want to do. I think the committees will go along with me.

Senator **Melcher**. Mr. Smith, what about firing Dolores Cantarella, who was the alcohol coordinator for this area.

Dr. **Exendine**. Mr. Chairman, if I may, may I answer that question?

Senator **Melcher**. You may answer it.

Dr. **Exendine**. I am very familiar with the case. Mr. Smith shared it with me earlier in the year. Here is basically what I instructed him. I would much prefer not to discuss it because it does come under the Privacy Act, and, therefore, rather than publicly discuss it, I would rather not do that.

Second, I assured him, or I instructed him, to advise the individual of her appeal rights.

Senator **Melcher**. We are going to advise her of her appeal rights, too, by the way. So we will be working with you on that.

Dr. **Exendine**. Right. I guess the other thing is with her permission, written permission, we would be more than happy to submit the documents to you, sir.

Senator **Melcher**. Well, we will review that very carefully. We are confronted continually with this problem of whether or not we are gaining ground on alcoholism, and there is a feeling that many of the tribes that are involved like Dolores Cantarella, if I am pronouncing her name correctly, that they were making some headway, and the committee, and myself in particular, will be very interested to know whether or not removing her was a constructive step at all.

I do have a question that touches on part of this, Mr. Smith. Why is the Brigham City service unit director also the administrator of an alcoholism program contracted to an intertribal board which acts as a health board? This gets a little bit complicated for me?

Mr. **Smith**. She is not serving in both capacities.

Senator **Melcher**. She is not?

Mr. **Smith**. No. The Inter-Mountain School has a school board that works with the Bureau of Indian Affairs in terms of advising and overseeing what goes on in relation in the school.

Senator **Melcher**. Did you fund that school board's members to be doing something other than a school board?

Mr. **Smith**. The part one portion of the school board's function is that they do serve also as an advisory board to us in terms of health issues. The original way the organization of the school board was set up was that it had membership from every tribe that had any students there, and it was a very unwieldy board. They then decided they would bring the board down to a reasonable number to handle school issues as well as health issues. They have also had a health board for quite a number of years. So when they consolidated down to a small number, they said we will also deal with health issues and health concerns that we have of our students.

Senator **Melcher**. What is the amount that you spend and what happens to the money? How many people are we talking about now on that school board?

Mr. **Smith**. I think six or eight, at most.

Senator **Melcher**. What was the amount of the contract that you spent with them directly?

Mr. **Smith**. Offhand, I do not know. I could find that for you.

Senator **Melcher**. Mr. Nielson.

Mr. **Nielson**. The contract for 1981 was roughly around $27,000.

Senator **Melcher**. Divided six ways?

Mr. **Nielson**. That was one contract. I do not know exactly six members of the school board; whatever their individual costs were, per diem costs, travel costs, their meeting costs. That is what is used for their meetings.

Mr. **Smith**. They do not put that on a per individual basis. What we did was we funded a program, a proposal, which they submitted, to operate a health board and advisory functions as well as some other services. So it was a submitted proposal by them which was funded.

Senator **Melcher**. All right; $27,000 went to the board?

Mr. **Smith**. Yes.

Senator **Melcher**. Do you know what they used it for?

Mr. **Smith**. Yes; we have a very well defined program. I do not have it with me.

Senator **Melcher**. You better submit that to us, please.

Now, there was an alcoholism contract with them, too, was there not?

Mr. **Smith**. We have provided them——

Senator **Melcher**. Was or is? Maybe was and still is.

Mr. **Smith**. There is. We are providing them through an NIAAA with $65,000, an NIAAA alcoholism grant.

Senator **Melcher**. That flows from NIAAA to the area office, and you are the conduit to them for that amount of money?

Mr. **Smith**. We are supplementing that for some detoxification services in the amount of $4,375.

Senator **Melcher**. If the Brigham City service unit director was not the administrator of an alcoholism program which was contracted to the school board—is her name Barcus?

Mr. **Smith**. Yes.

Senator **Melcher**. Why did she sign the check then?

Mr. **Smith**. I am not aware that she did.

Senator **Melcher**. Inter-Mountain National Inter-Tribal School Board, Inc., Brigham City, Utah, made out to the finance officer of the Billings area office, and signed by Barcus.

Mr. **Nielson**. I have not seen a copy. One thing that could be, would be that we have a reimbursement agreement with the BIA for the use of that facility. We pay the BIA for that. But I am not really familiar with that check.

Senator **Melcher**. She is the Brigham City service unit director. That is a Federal employee under this area office, right? We are wondering if she is the administrator of the alcoholism program?

Mr. **Smith**. She has no authority to be so. I will follow up on that because that is the first I have heard of that, because she has not had the authority to serve as an administrator for that program.

Senator **Melcher**. She does not have that authority?

Mr. **Smith**. She does not have that authority. Her role is to work very closely with that organization, and that's——

Senator **Melcher**. She is a full-time Federal employee, right?

Mr. SMITH. Yes.

Senator MELCHER. So, it would be contrary to law for her to be the program director or even a program administrator or even working for them, is that not true?

Mr. SMITH. There is no authority for that.

Senator MELCHER. We would appreciate you clarifying that, Mr. Smith.

Mr. SMITH. Most assuredly, sir.

Senator MELCHER. It has been brought up that water and sewer grants would not be funded under IHS, but you can transfer to HUD, if I understood that correctly, is that true?

Dr. EXENDINE. Not to my knowledge. I might add, there is a lot of discussion going on in Washington, who should have the housing program? There are some discussions, rumors, that HUD should take it over, Interior should take it over, we should take it over, but I have not seen anything concrete on it.

Senator MELCHER. Well, I have had the occasion a time or two to deal with IHS on what seems to me to be a very tough water proposition in terms of health. Now, you are not going to relinquish any authority on that aspect, are you?

Dr. EXENDINE. We hope not.

Senator MELCHER. Well, I am with you, because that is a little bit different than just building houses or maintaining houses. That could be a very severe health question.

Dr. EXENDINE. I think it would be worthwhile to point out, as far as I know we probably have the largest engineering and sanitarian staff in the Federal Government. Therefore, I could not see them really transferring that authority over to someone else.

Senator MELCHER. We are going to be very alert and viligant on that as a committee.

I would like to ask Dr. Lois Steele, who I think is here, could you come up here, Dr. Steele?

We have been very hopeful for the Indians Into Medicine program at the University of North Dakota. Can you tell us what the budget cuts are going to do to your program, or our program?

Dr. STEELE. Well, I do not know. I talked to Dr. Exendine about that this morning. He can probably answer that better than I.

Dr. EXENDINE. Let me tell you what I think I know. In the past 2 years, last year, year before last, we funded the InMed program $620,000. Last year we funded it at approximately $700,000. And the language that is in the——

Senator MELCHER. That is an increase. We will note that.

Dr. EXENDINE. Right, it is an increase. And I might add the InMed program is an excellent program.

In reading the language that is in the Senate report, it is my understanding and my own interpretation, that it means $200,000 of the actual $620,000 can be used for administrative costs, overhead, and the remaining will go for scholarships and support staff for the students. Hopefully my interpretation is correct. In other words, I guess to be more specific, that the InMed program will continue to be funded at the $620,000 level minus the 4 percent.

Senator MELCHER. Now, Dr. Steele, I understand you work as a physician on weekends on the reservation.

Dr. STEELE. Whenever we do not have to get a proposal ready, yes.

Senator Melcher. A proposal ready for InMed?

Dr. Steele. Yes, or a report, or those kind of things.

Senator Melcher. Paperwork: you have a lot of that too?

Dr. Steele. Oh, yes.

Senator Melcher. A brandnew program: can we not start out with a model of no paper work that takes up no more than an hour or two a week?

Dr. Steele. That would be nice.

Senator Melcher. Is that possible?

Dr. Steele. Yes, but we have to trust each other in order for all that to happen.

Senator Melcher. Why do we not use that. InMed is pretty new yet. Would you have any suggestions to pass on, both to IHS and to this committee on how you could simplify all that reporting?

Dr. Steele. Meetings like this can help. It really can. We have an InMed advisory board and we were meeting four times a year, but we will be able to meet only two, it looks like. Then we sit down and we try to talk so everybody knows what is happening. We listen to each other, too, and that builds pretty good trust, I think, and our board, when we have questions over whether or not a student should be selected, and we question it, we take it to the board, and the board makes the decision. We have not had any complaints from the tribes as to who we have selected. Now, I think that is pretty good.

Senator Melcher. That is pretty good. The jury has been supporting you.

Dr. Steele. You bet.

Senator Melcher. That is a pretty good recommendation.

Well, when you go to the reservations on the weekends to assist in providing some medical treatment to sick patients, what have you observed during the past several weeks after this series of budget cuts?

Dr. Steele. I have been so busy trying to get with the budget cuts, I have not been able to go out, but I get to go home.

Senator Melcher. That is another drawback to the budget cuts. You are too busy keeping up on paperwork.

You know, I think this Congress and all the bureaucracy that is [illegible]volved with the Federal Government, has had to spend far too mu[illegible] time in dealing strictly with how to either absorb budget cuts or avoid budget cuts or even answer the questions for OMB or for—well, OMB and the White House, one and the same practically—and for Congress, as a matter of fact, we are always asking what's going on. I think it has taken an inordinate amount of time. But we have heard testimony today from some of the people who testified, that we understand there are going to be budget cuts, and it is a fact of life. Now, it is a question of how we can deal with them and not jeopardize health care.

I want to compliment you Dr. Steele, for your voluntary work on these weekends. I suspect you are not paid for that, are you?

Dr. Steele. I get paid OK.

Senator Melcher. I am glad to hear that, because I would like to see more people doing it.

Dr. Steele. Well, it is really a part of my salary, and if I am going to maintain credibility, you know, I have to go out and work. I did not go through medical school just to push paper.

Senator **Melcher**. Good for you.

Dr. **Steele**. So there are a lot of things that I can do.

Senator **Melcher**. Now, Dr. Exendine, as acting director in your next 60 days or so, before we get the new director, I wonder if you would mind giving this committee some suggestions. I will take the little one first. I have two requests, I will put the little one first. No. 1, I know you have implemented what you have had come in from the area offices on how to cut down on paper shuffling, but perhaps you have some more recommendations, and we would like to have them on that count.

Dr. **Exendine**. Be more than happy to.

Senator **Melcher**. I really believe we have burdened ourselves too much with paper work, and I think it is very costly.

No. 2, I would like to request that you make your recommendations both to Dr. Rhoades and to this committee on how to better cope with the existing level of appropriations that are available for Indian Health Service to deliver more health care to the people themselves and cut down on the overhead, particularly at the area offices.

Now, we have been—this committee, during the past 4 years, and I could almost say 5 years—has been pursuing the goal of more of the dollars being spent actually for health care and less on the overhead We would like your assistance on it.

We understand, as you understand, while Indian Health Service has not been cut as much percentagewise as many of the rest—most of the rest of the Federal programs, except national defense—that a fact of life is the inflationary costs of health care services, and when you take a 10-percent cut or, say, it ends up around 8 or 9 percent, I believe that is about realistic, from what it was. Am I correct? As far as we know it will be about an 8- or 9-percent cut from what it was last year?

Dr. **Exendine**. Actually, it will figure out about—counting the conferee's agreement—it will be about 14 percent.

Mr. **Nielson**. In actual dollars for the operating health service it was $607 million. This year it is $599 million. It works out about 1 percent. But if you take inflation and the other costs it comes to between 8 and 10 and 15 percent. I really have not computed that.

Senator **Melcher**. You said 14. Is that counting inflation?

Dr. **Exendine**. Counting inflation.

Senator **Melcher**. That is what we have to do, because it is there. Those costs are very real. I believe it is imperative that we attempt to find better ways of getting more of those dollars out for actual health care so we don't have to worry about whether the sick patients or preventive health care is really being delivered to the people.

We have also been working with IHS on estimating what the contract care costs are going to be, and to arrive at the best amount deliverable health care for every dollar spent under contract care. That is an ongoing proposition with us, and if you have some suggestions on that, I will make that the third request along with my other two.

Dr. **Exendine**. Certainly.

Senator **Melcher**. Well, thank you all very much for your testimony.

Dr. Exendine, your prepared statement will be made a part of the record at this point.

[The prepared statement follows:]

PREPARED STATEMENT OF JOSEPH N. EXENDINE, ACTING DIRECTOR, INDIAN HEALTH SERVICE, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee:

I am Dr. Joseph Exendine, and I am the Acting Director of the Indian Health Service. I appreciate the opportunity to testify this morning on the Fiscal Year 1982 budget of the Indian Health Service. I am accompanied this morning by J.R. Smith, Director, Billings Area Office, Indian Health Service; Eleanore A. Robertson, Director, Aberdeen Area Office, Indian Health Service; and Lois Steele, an Indian Health Service employee detailed to the University of North Dakota as Director of the University's INMED Program.

As you know, Mr. Chairman, the Indian Health Service represents the primary Federal health commitment to approximately 865,000 eligible American Indian people and Alaska Natives living on or near Federal Indian reservations or in traditional Indian country such as Oklahoma and Alaska. In addition, limited health services are provided in 41 urban locations having an estimated Indian population of 300,000--half of whom are included in the 865,000 figure mentioned earlier. In Montana, the Indian Health Service service population is approximately 33,000. In addition, 8 of the 41 urban projects are in Montana. The Indian Health Service is constantly endeavoring to provide quality health care to these individuals, while always recognizing that the medical needs of Indian people demand a special measure of priority and attention from the Federal government.

For Fiscal Year 1982, a budget of $646.8 million has been approved by the Congress for the Indian Health Service, a decrease of $42.9 million from the 1981 level. The budget includes $599.7 million for Indian health services and $47.1 million for Indian health facilities.

Because this budget was only approved by the Congress on December 10 (as part of the Interior Appropriations bill), I am not able to provide you with a breakdown of the specific impact on the Billings and Aberdeen areas. However, I can provide the following national breakdown of the budget:

Specifically, the FY 1982 health services budget includes:

- $312,139,000 for hospital and health clinic programs;
- $ 17,884,000 for dental health programs;
- $ 7,488,000 for mental health programs;
- $ 16,290,000 for alcoholism programs;
- $ 8,267,000 for maintenance and repair;
- $110,427,000 for contract care;
- $ 14,090,000 for sanitation services;
- $ 7,969,000 for public health nursing
- $ 2,194,000 for health education;
- $ 28,800,000 for the community health representation program;
- $ 8,160,000 for urban health projects;
- $ 5,760,000 for Indian health manpower;
- $ 2,634,000 for tribal management;
- $ 48,851,000 for program management; and
- $ 13,492,000 for the Equity health care fund;

The 1982 budget for Indian health services includes funds to staff and operate several new facilities selected to open in Fiscal Year 1982 and to serve newly recognized tribes. The 48 Indian Health Service hospitals will provide services for approximately 82,000 inpatients. In addition, the 48 outpatient departments, 98 health centers and the more than 300 satellite clinics will provide an estimated 3.4 million outpatient visits, approximately the same number of visits as the Fiscal Year 1981 level. Training will be provided to approximately 500 Indian students for the health professions.

Since the beginning of Fiscal Year 1982, we have continued our basic programs under the Continuing Resolutions without serious interruption. This was accomplished through such means as no cost extensions, short term contracts and grants and various other methods to cover this period of budgetary uncertainty.

Mr. Chairman, that concludes my opening remarks. At this time I will be happy to answer any questions you may have.

Senator **Melcher**. The hearing is adjourned subject to the call of the Chair.

[Whereupon, at 2:15 p.m., the hearing was adjourned.]

FEBRUARY 15, 1982

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Phoenix, Ariz.

The committee met, pursuant to notice, at 8 a.m., in the Maricopa County Board of Supervisors Auditorium, Phoenix, Ariz., Senator Dennis DeConcini (acting chairman) presiding.

Present: Senator DeConcini and Senator Goldwater.

Staff present: Peter Taylor, general counsel; Max Richtman, minority staff director; John Mulkey, legislative assistant; and Robert Maynes, press secretary to Senator DeConcini.

Senator GOLDWATER [presiding]. The hearing will come to order.

Senator DeConcini has been delayed and will be here shortly. In the interest of time, and because I know most of you have other things to do today too, we will get started.

I want to compliment Senator DeConcini on asking for this meeting. It is a meeting, frankly, that is long overdue, because there is one thing our Indians in this part of the United States have not enjoyed to any great extent, and that has been adequate medical attention. I think the reservations comprise 27 percent of the lands of Arizona and with the number of hospitals they have—it is impossible to believe that a country like the United States should have paid such very poor attention to the health of these people all of these years.

I remember when the hospital at Sells burned down. It took 10 years to get a new hospital, and it is not big enough now for more than a good-sized family. We have had the same problem all over Arizona. I do not think I can name a tribe that has adequate medical attention. When you take into consideration the 16 million acres of the Navajo Reservation and the fact that we do not have adequate communications yet—but we are beginning to get them, so that they enable a trader or an Indian at a trading post to tell the Health Service when they need one doctor, two doctors, one nurse, or two or three nurses. It is understandable how things get mixed up on that giant reservation, and the same thing applies to our smaller reservations who, I frankly suspect, have never seen a doctor on the reservation.

Again, I congratulate Senator DeConcini for calling this meeting, and I am happy to be here myself. I cannot stay too long.

To get this meeting started we have the Inter-Tribal Council of Nevada, Mr. Robert Summers, director, who will speak on alcoholism and the drug education program.

Mr. Summers.

STATEMENT OF ROBERT SUMMERS, DIRECTOR, ALCOHOLISM AND DRUG EDUCATION PROGRAM, INTER-TRIBAL COUNCIL OF NEVADA

Mr. SUMMERS. Thank you, Senator.

I would like to discuss some of the problems we are experiencing in Nevada, and I refer to alcohol and its abuse among the native Americans.

Alcoholism among American Indians is their most significant health problem. The Resource Allocation Task Force on Alcoholism, April 1979, suggests that 95 percent of all American Indians are affected by alcohol abuse. The National Clearing House on Alcohol Information indicates that among all special groups in the United States, American Indians have the highest reported frequency of problems associated with drinking, and alcoholism is the principal disruptive element in the stability of the Indian community as the Department of Health, Education, and Welfare suggested on February 15, 1978.

Five of the top 10 causes of death among Indian people are directly related to alcohol abuse or alcoholism, and these are: Accidents which are 75 percent alcohol-related; alcoholism itself, which affects 95 percent of the population; suicide, which is 80 percent alcohol-related and is 4 times the percentage rate of the Nation; homicide, which includes 90 percent alcohol involvement by either the perpetrator, the victim, or both; cirrhosis of the liver, which, among Native Americans, is 3 times the national average.

The overall mortality rate from all causes associated with alcoholism in American Indians is 11.1 per 1,000 or 22 times the national average.

Additional contributing factors to Nevada's Indian population problems include unemployment, poverty, and education, as reflected in these figures: The average unemployment rate in Nevada for Indians is 40 percent, while the average unemployment rate for Nevada citizens, in general, is 7.5 percent as of November 1981. Thirty-two percent of the tribes have unemployment rates in excess of 50 percent. Of those working, two-thirds make less than $7,000 annually, and 32 percent earn less than $5,000 annually, 87 percent have not completed high school due to distance, resources, the closing of BIA schools, and myriad other reasons.

Where once the health of our Native American citizens was threatened primarily by alcoholism, suicide, and cirrhosis, today it is equally threatened by inflation, recession, and budget reductions.

Now to address the more specific impact of the 1982 budget reductions on IHS funded and operated programs using our scope of work contract for services.

No. 1, to develop a comprehensive treatment program. I had written an unsolicited grant to IHS to provide the first and only culturally specific, 16-bed residential treatment center to serve the 13,250 Native Americans in the State of Nevada. On March 10, 1980, it was funded for $80,000 per year. Since the average funds in the Phoenix area for treatment centers is $117,000, we are operating at $37,000 less than the average and doing so effectively.

In order to maintain 24-hour coverage, to provide continuity of treatment, and to maintain efficient fiscal cost containment management, we utilize our 5 staff members on a firefighter schedule, that is, each works one shift of 24 hours and then is off 72 hours.

I have been advised by IHS that the center will not be funded after May 31, 1982, due to budget reductions.

As appendix A[1] illustrates, the center is necessary, and it serves the entire population of the State. It is effective and cost efficient, but it will be defunded without considering the evaluation results, which show that, statistically, every objective has been met, and the population served has benefited.

A financial concern appropriately addressed here, is that the IHS comparison of fiscal year 1981 and fiscal year 1982 appropriations regarding tribal health delivery shows that alcoholism programs received an increase of 6.9 percent—that is, the 1981 appropriations were $15,237,000, and the 1982 appropriations are $16,290,000. While ice and embers in the same bowl cannot lie, we are being asked to accept a similar dichotomy. I have been advised that the Phoenix area has not received the 6.9 increase and is faced with an additional 10-percent decrease, a total program decrease of 16.9 percent. Needless to say, this raises myriad questions.

We are charged with providing outreach services. Outreach counseling and education are the foundations upon which we anticipate long-term changes in the reduction of alcohol abuse by our youth, primarily, and by those at risks, generally.

The budget reductions will reduce from one to three counselors from the staff of service providers. When one realizes that Nevada has 111,000 square miles, has only 2 major population centers, has 23 tribes located in the remotest areas of the State and that each counselor has a universe of discourse of 500 Indians in need, then the loss of service to 500 to 1,500 individuals is an impact inconsistent with the minimal health standards to which we all subscribe.

Next, development of community support systems. In populated areas where health service duplication may exist, one can mentally accommodate reductions and mergers. The reservation and colonies that will be affected by the budget reductions have not been afforded the luxury of multiple services. Some reservations have only one phone to service the entire community, are located 100 to 500 miles from a major populated area, are an average of 200 miles from IHS hospital services, and rely only on their local human resources as a support system.

I believe individuals outside the Indian influence have a mental set that is derived from large corporate organizations, namely, that a reduction of services can be accommodated and assumed by the remaining personnel. While this position is defensible, it is absolutely untrue of isolated, remote, poverty-level communities typified by many of our colonies and reservations.

We must provide staff development. The State of Nevada requires that counselors be State certified, a process that demands one-half day of written testing and an additional oral interview for those who pass the written exam. The certification of Indian counselors is essential to interfacing with the non-Indian judicial system. Competent counselors counsel competently. IHS budget cuts will reduce the training delivery days and ultimately adversely impact on prevention and treatment results.

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[1] Appendix material retained in committee files.

Evaluation of the program. "Unless you are keeping score, it is difficult to know whether you are winning or losing." The alcohol treatment and guidance system [ATGS] is a well-planned, precise method of keeping score as well as a viable treatment guideline. Unfortunately, keypunch operator and other personnel were not funded, and in the year or so of its data collection, a minimal amount of output has reached the field or, in fact, been produced. This means that the across-the-board budget reductions are being made without regard to keeping score of the efficient, cost-effective programs. The net result being that the efficient programs are reduced or cut at the expense of inefficient programs surviving and continuing to waste already short supplies of service dollars.

This concludes my oral testimony. If I may be of further service, please call on me.

Senator Goldwater. Thank you very much. That is rather shocking testimony.

Has there ever been a decision reached on why Indians seem to drink more than the rest of the population?

Mr. Summers. There has been a great deal of study of alcohol and alcohol problems, and they are still bandying about the concept that there are genetic factors involved. But, I think most of the people subscribe to the fact that if an individual has a stake in society, then they will be less likely to abuse alcohol. Those that do not have a stake in society tend to abuse it. My impression is that if you are primarily concerned about food, clothing, shelter, work, and those kinds of daily physiological living conditions, alcohol becomes a method of relieving some of the tensions and anxieties.

Senator Goldwater. Would it not be the same as it would be in the non-Indian population?

Mr. Summers. Perhaps, but we contain the Indian population in very remote areas in our State, and if they leave the reservations, they lose those kinds of benefits that they are entitled to on the reservation. The Indians have a very difficult time getting into society, and this remoteness promotes drinking.

Senator Goldwater. I have not looked in the appendix, but, just generally, what is your opinion of the results that you have been able to achieve with this program?

Mr. Summers. I should take the part of a diplomat or a salesman and suggest that our results are 15 to 25 percent. Realistically, I believe we are getting about a 5-percent recovery rate.

Senator Goldwater. Any questions you want to ask?

Mr. Mulkey. Mr. Summers, you mentioned in your statement that you received a 6.9-percent increase from IHS, in its alcohol programs, but you said that the Phoenix area was having a decrease. Can you explain or can someone explain why this is the case?

Mr. Summers. No, I cannot explain why. The Indian Health Service budget justification for 1982 is in appendix A, and in the Congressional Record on December 10, 1981. This is where the 6.9-increase figure was obtained. I am being asked to reduce my budget, generally, by 10 percent. That is 10 percent of the entire program for the State and additionally deleting entirely the only residential treatment center that services the Indian population. I do not know why the discrepancy exists.

Senator **Goldwater.** I think you might find it partly in the fact that our largest immediate access to Indians would be the Salt River Pimas, and their land values have grown remarkably fast. They are proving to be a very competent tribe in taking care of themselves, and the reason would be, I think, that they probably live a little better than the average Indian immediately around here.

Mr. **Summers.** We have a similar situation in Nevada. We have four tribes that have done remarkably well and have utilized the services they have received. Where our greatest problems exist are in those small tribes that are the greatest distances from any service and, in fact, from any population, and it is difficult for them to have access to the kinds of economic opportunities that one would normally consider beneficial.

Senator **Goldwater.** Where would the Winnemucca fit in? They are a remote tribe, are they not?

Mr. **Summers.** Yes, they are.

Senator **Goldwater.** Do you have any problem there?

Mr. **Summers.** Yes, it is a small colony in Winnemucca, and with some industry moving in they may now have the possibility of increasing their economic situation, but up until very recently they have not had that opportunity.

Senator **Goldwater.** Well, I thank you very much, Mr. Summers, and you have given us some remarkably frightening testimony. Thank you.

Mr. **Summers.** Thank you, gentlemen.

Senator **Goldwater.** We will see what we can do.

Mr. **Summers.** Thank you.

Senator **Goldwater.** The next witness will be—is that Millett or Millett?

Mr. **Millett.** Jerry Millett.

Senator **Goldwater.** Jerry Millett, Inter-Tribal Council of Nevada, Health Committee.

STATEMENT OF JERRY MILLETT, CHAIRMAN, HEALTH COMMITTEE, INTER-TRIBAL COUNCIL OF NEVADA, ACCOMPANIED BY SHARON COLEMAN, RESEARCH ANALYST

Mr. **Millett.** Thank you, Senator.

I am Jerry Millett, chairman of the Duckwater Tribal Council, Shoshone Tribe, in Nevada, and also the chairman of the Health Committee of the Inter-Tribal Council of Nevada.

Appearing with me is Sharon Coleman. She is the research analyst of the Inter-Tribal Council of Nevada Health Committee.

Our testimony concerns the impact of the Indian Health Service's fiscal year 1982 budget on the medical services available to Nevada's Indians. Nevada is a large State. It is over 110,000 square miles, as Mr. Summers said.

Senator **Goldwater.** You have not stolen Clark County from us?

Mr. **Millett.** We have two Indian Health Service hospitals: Schurz in western Nevada and Owyhee in northeastern Nevada. The average traveltime, for all tribes, is 2½ hours, one way, to these hospitals. The Schurz and Owyhee facilities only offer primary and convalescent medical care. There facilities do not provide obstetrical, surgical, pediatric, or secondary medical services. Less than 50 percent of all conditions requiring hospitalization can be treated at these IHS facilities.

The balance of medical services must be provided through contract health services funds. The high demand on CHS dollars and the skyrocketing costs of health care have not been matched by similar increases to the CHS budget. This has resulted in denials of service and backlogging of necessary medical care. Problems that initially are not critical often develop into more serious cases due to the lag in treatment time. The severe strain on the CHS budget in Nevada has forced a service unit policy of only providing emergency care halfway through the fiscal year. In 1981 both service units ran completely out of funds by September and no services were provided at all.

At the close of fiscal year 1981 the service units estimated that $103,000 in surgical funds and over $282,000 in CHS funds were needed to cover unmet needs. Using first-quarter fiscal year 1982 funds to cover the 1981 medical needs will compound the dilemma for this fiscal year since funds allocated do not even meet inflation's costs. The CHS budget only realized a 9 percent increase over 1981 obligations. Inflation in the medical industry is currently at 17 percent.

The closure of the Public Health Service facility in San Francisco will introduce an added $250,000 burden to the Contract Health Service budget. The Indians of Nevada have very limited access to the Phoenix Indian Medical Center.

Despite the lack of services available through IHS, an estimated 80 percent of the health services received are either provided for or purchased by IHS. A small percentage of the health care is purchased through medicare or private insurance. The majority of Indians in our State cannot afford to purchase health care.

I am asking Congress to review the critical deficit of health services available to Nevada's Indian population. $595,000 in contract service funds are needed to cover both service-units clients' unmet medical needs from 1981. In clinical service funds $911,000 are needed to keep the doors open of our two facilities in Nevada. We urge Congress to either earmark these funds to Nevada or follow through on its directive to IHS to develop methodologies to redistribute the base program and equity funds, so at least all tribes can receive similar services.

The tribes in Nevada are also concerned with the threat to preventive health services if Congress slashes the funding levels of the Community Health Representative program budget below the 1981 funding levels. In order to compensate for the lack of available medical services in Nevada, PAIHS, along with the tribes, developed a strong preventive health program consisting of direct services and health education. These programs received a serious blow to their ability to provide consistent and skilled care when Congress voted for a 20-percent slash in the CHR 1982 budget.

The Indian Health Service has ignored Congress' directive to reduce the CHR program only in areas which have higher concentrations of health personnel and clinics or hospitals. All CHR programs were cut the full amount across-the-board. Nevada's outreach medical services are almost entirely dependent on CHR-funded programs.

Travel restrictions for IHS medical staff and the curtailment of field clinics in 1981 have made the services of CHR staff critical in the delivery of direct health care. Due to the large numbers of elderly and infirm in Nevada, IHS established an in-home health service program to provide direct health care as an alternative to institutionalization. This program has proven to be both cost effective and cost beneficial, yet it has been continually eroded by a lack of funds. During January 1982. IHS informed the program that its budget was being reduced 20 percent retroactive to October 1, 1981. The evaluation of client problems for early referral and treatment will certainly suffer. Reductions in our program services come at a time when other agencies are also reducing their services. There are no other agencies to fill in the gaps. The services are simply lost.

Examples of services that will have to be eliminated or reduced include: Interim clients; meal deliveries; transportation of clients; staff training; many nursing services; patient education; routine monitoring; preventive activities; in-home care. That program has strived very hard to expand its medical components. However, if this type of care is unavailable, clients will need to be placed in extended care facilities, certainly a more expensive and less satisfactory solution. Our concern is that without these services who will be taking care of our people?

That concludes our testimony, Senator.

Senator GOLDWATER. Thank you very much.

Did you say you do not have an Indian Health Service hospital in Nevada?

Mr. MILLETT. We have two. One is in the northeastern part of Nevada, and the other is in the western part of the State.

Senator GOLDWATER. How many beds do they provide?

Mr. MILLETT. I believe the Owyhee service unit is 15 and I do not know at the Schurz Health Service hospital.

Senator GOLDWATER. Years ago, and I do not know if it has been corrected or not, we had a pretty large Indian hospital here for a good many years. Surveys showed that most of the patients were not Indians, even though they might be 32d or 36th blood. I am wondering if you run into that problem up there.

Mr. MILLETT. Not that I am aware of.

Are you, Sharon?

Senator GOLDWATER. I remember a bill I introduced. It did not get very far. It was an Indian bill. I wanted to require anyone who benefited from Indian programs to have at least one-eighth blood, but the unreal Indians rose up and we did not get to first base.

Do you have any questions?

Mr. MULKEY. No, sir.

Mr. TAYLOR. No.

Senator GOLDWATER. Well, thank you very much for coming down here, and thank you for coming, Ms. Coleman.

The next person on the program will be Jane Harrowa, Chairperson of the Nevada Urban Indians. Is Ms. Harrowa here?

Well, in her absence we will call on Mr. Bob Angle. Mr. Angle is executive director of the Salt Lake City Indian Health Center. Welcome.

STATEMENT OF BOB ANGLE, EXECUTIVE DIRECTOR, SALT LAKE CITY INDIAN HEALTH CENTER

Mr. ANGLE. Mr. Chairman, I am very pleased to be here today to represent the Salt Lake Indian Health Center of Salt Lake City, Utah. I am the executive director, and I would like to say that the Salt Lake Indian Health Center provides health care and service to approximately 8,400 American Indians in the Salt Lake City area. Right in the Salt Lake City area 5,000 of them reside. About 85 percent of these Indians travel from the Navajo reservation to the Salt Lake area, and some of them are arriving in the city for the first time seeking employment or educational opportunities; trying to, perhaps, adjust to the urban lifestyle.

A lot of these people are Navajo-speaking people. They have a difficult time adjusting to the urban way of life. For these people and many others the Salt Lake Indian Health Center provides a tremendous amount of health service for the few dollars we received this year. In Utah we received $160,000. With this money we have provided many services, and we have many volunteers that we use in the center.

The Northwest Family Practice Center is giving us a PA and a mental health nurse. We also have a podiatrist. We have other volunteer nurses. We have a volunteer optometrist, and with these volunteers and the staff that we pay for, a nurse, a WIC coordinator, clerical and administrative support, we provide the following health services: A general health clinic, a WIC infant-children program, podiatry, eye clinic, mental health counseling, immunization clinic, blood pressure screening, tuberculosis testing, diabetic clinic, prenatal classes, weight reduction program, outreach and referral, family planning, and a well-child clinic. As you can see, it is a very comprehensive program that we are providing for the people.

For the last 3 months our average client contact was 484 clients per month. Our cost per client contact is about $27 per client contact, and most of those clients are seeing some type of health provider, mental health counselor or a PA or an optometrist or podiatrist.

As a director, I am really very concerned about the budget cuts and the impact it will have on the Salt Lake Indian Health Center. Although we have been trying very hard to obtain local funding, I think the likelihood for our center to obtain the necessary funding to keep our programs operating is very slim. If the proposed budget cut of cutting the Indian health money is to zero this coming year, I feel our program will probably be eliminated. I think this would be very bad for the urban Indian because I do not think they will get the type of health care that they need.

I would like to share with you some statistics on the health of Utah Indians, which I think is very shocking evidence of why the Government appropriated moneys for the urban Indians' health care in the first place. According to the Utah Vital Statistics Annual Report, from 1968 to 1975 the median age of death for Indian people in Utah was

35.7 years, whereas the median age of death of whites during that same time was never below 69.0 years. Also the statistics between 1968 and 1975 show that for Utah Indians there was an average of 35 deaths per 1,000 live births, whereas for the rest of the Utah population there was an average of 14 deaths per 1,000 live births. Many of the Indians that we serve are Indians that travel back and forth to and from the reservations, and I believe that those statistics relate to the people that we serve.

I think one of the reasons why they cut our Indian health moneys is because they fail to see our budget from the standpoint of cost effectiveness and the concern to improve the economy. I think that we ought to look at the cost effectiveness of our programs. I think it would be best for us to keep our programs—the programs like the Salt Lake Indian Health Center—open and providing services.

I would like to give a couple of examples. No. 1, if we offer prenatal care to our clients, it will cost approximately $500 per case. If an individual does not get proper prenatal care and a premature or sick baby results, the care could very well cost as much as $200,000 or $300,000. The Salt Lake Indian Health Center could run for a year or two on what it would cost for one neglected pregnancy.

The second example I would like to give is an infected ear that goes untreated and could lead to chronic infection, loss of hearing, and meningitis. All of these sequelae are much more expensive to treat than treating the original infection.

If our program were to close, I think that there is a lot of urban Indians that would go without care, and I think it is important for the people in the positions of decisionmaking, that they can relate to these people that would not be receiving the care that we are now providing. The two examples that I am going to give are examples that came through the center only last week, and I think they represent the kind of clients that we are serving.

First, a young mother, 2 months pregnant came in seeking help for herself and her 2-month-old child she was still breast feeding. She had been selling her blood to survive in the city.

Senator GOLDWATER. Senator DeConcini has arrived and will now assume the chair.

Mr. ANGLE. I am in the process, Senator DeConcini, of giving some examples of the type of cases that we see in our clinic. The first one is a young mother, 2 months pregnant, who came in seeking help for herself and her 2-month-old child that she was breast feeding. A lot of times the Indian people, when they find themselves without any money and they are on the streets, they will go to a place where they can sell their blood. This particular mother with a 2-month-old child was frequently going down selling her blood in order to survive in the city.

Our PA examined this mother and his examination did reveal acute anemia due to malnutrition and blood loss. Her infant girl was examined, and the little girl was found to have a deformed ear due to a birth defect. Primary care was given and appropriate referral was made to the health and social service agencies in the city to help this person, and we will follow up with those referrals. We expect this patient will continue to come to the center until the crisis situation is over.

The second example, which happened last week, is a teenage couple that came into the clinic looking for help. She is 18 years old, and he is 17 years old. They were looking for medical help because she is pregnant. She is 7 months pregnant. She had never seen a physician during the 7 months of pregnancy. While she was sitting in the waiting room, she was hemorrhaging. The young 17-year-old father was frightened to death, and she was also frightened. The young man's thought was to find some way to get back to the reservation where he could get medical care.

I think it is really interesting. It should be important to you to understand, I think, the distance between Salt Lake City and the medical clinic on the reservation. In this particular case it was approximately 400 miles, and the boy did not have an automobile, did not have much money, but he was trying to get his wife back to the reservation and help her in the best way that he knew how.

The PA examined them and gave them the care that they wanted, and it wasn't necessary for them to go back to the reservation. I think this is really a good example of what is taking place in the urban areas. These young people are not getting prenatal care. They are waiting till the 8th month, the 9th month. Then they come in for an examination for the purpose of finding out when they have to go back to the reservation. They go back to the reservation to get health care, and in almost every case that would not be necessary.

I would like to end by saying that about half the American Indians in the United States live in urban areas. The moneys that you have appropriated for urban Indian health care is only $8.2 million, which is very little to provide health care service for the 41 urban Indian health care projects in the United States. I think the good that our centers are doing and the need for the centers to provide services for these people is great. We feel good about the services that we are providing, and I think it would be a terrible mistake to cut the little moneys that you are providing for all of the Indians that are in your urban areas.

Senator DECONCINI [presiding]. Thank you very much. I understand this year's budget was only $8 million. I realize that $8 million is a lot of money, but in comparison to other Indian health programs, it is one of the smaller appropriations; is that correct?

Mr. ANGLE. Yes; $8.2 million for fiscal year 1982 and for fiscal year 1983, and I would like to say that the budget cutting that is going on at the Federal level is also going on at the local level and State levels, especially in Utah. The likelihood of these programs being picked up by another agency are very slim, and even if we were to try to implement this idea of the new federalism, I think it would take us a lot more years than just 1 year to find the local funding that we need.

Senator DECONCINI. You do not see any other funding available, philanthropic or otherwise, to assist or to get any funding now for the urban centers?

Mr. ANGLE. I think right now we are doing all that we can to find local funding. There are some possibilities, but I think that in most cases for the 41 Indian urban health centers, there are probably very few of them that can find funding to keep their programs operating.

Senator DECONCINI. Thank you.

Senator Goldwater, any further questions?

Senator GOLDWATER. You indicated a large percentage of your Indians come from the Navajo Reservation.

Mr. ANGLE. Yes.

Senator GOLDWATER. Are they pretty stable, or do they come up to Salt Lake and then go back to the reservation?

Mr. ANGLE. Most of the Indian people, I think, are attempting to make the adjustment, and they are finding the adjustment so difficult to make that they return to the reservation, and in 1 or 2 years they may try it again. Because of their lack of skills it is difficult for them to compete for, you know, jobs in the city. They are unfamiliar with the processes and the procedures that they have to go through to get health care and other kinds of social services. A lot of times they do not have a dime in their pocket, and the adjustments to the culture, the differences in cultural values, I think, play a big part in this. They just become so frustrated that they go back to the reservation, to a place where at least they can get some health care and they have a place to stay. So, a lot of them are, like I say, moving to the city and back again. Back and forth.

Senator GOLDWATER. Your figures indicate that a great percentage of the problems for our Native Americans have come from trying to urbanize, moving into non-Indian centers of population.

Mr. ANGLE. I think that is so.

Senator GOLDWATER. I do not believe that the education offered the Indian on the reservation in any way prepares him or her to compete with the non-Indian in the community. Would you agree about that?

Mr. ANGLE. I think so. I think the moving is an extreme cultural gap that these people need to adjust to. I think that it is so extreme that very few people understand it unless they are experiencing it, and I know that is one of the reasons why we would feel bad if centers like the Salt Lake Indian Health Center were to close their doors. It is very much needed. I am just almost overwhelmed every day because of the clients that are coming in needing some place where they feel comfortable, where they feel like somebody cares for them, where somebody will take the time to try to understand what their needs are. Because we are providing that type of service, they are coming to us, and they are gaining access to the services, but I think that the moneys we are receiving are so small that with the budget cutting that is going on we would be happy with the moneys we have in order to keep our program operating. We need a lot more money, but we would be pleased with just a little bit of the moneys that we are not having——

Senator GOLDWATER. Have you ever approached the Mormon Church for help?

Mr. ANGLE. I think that people have the perception that the Mormon Church is rich, and because we are living in Salt Lake City that we get a lot of help from the Mormon Church. It is true that the Mormons have social and health and welfare programs, but it is basically for Mormons. Most of our Indians in Salt Lake City are not of that faith, and so they do not get those services, and when we go to the Mormon Church they say that is against their policy to provide moneys to agencies outside the church organization.

Senator GOLDWATER. Let me ask you one unrelated question, because you are coming in contact with health problems so often. What kind of progress are they making against trachoma; that old eye disease that they had for so long?

Mr. Angle. Well, from the last statistics I read, I understand that there is significant progress being made with that disease. At our center, we just recently implemented an eye clinic, and I know we will probably have more information on that later.

Senator Goldwater. Thank you very much.

Mr. Chairman, the more I travel around our reservations and the more I listen to the problems of Indians all over this country, the more I am convinced that the basic problem is education. If you would ask me what is the basic problem we have with 400 different Indian tribes, they would have only one common problem, and that is education.

Senator DeConcini. Or lack of it.

Senator Goldwater. I would hope that when we get back and get our committee cranked up, we will put a real emphasis on it. These people have great skills. The Hopis are probably the best masons you will ever run into. The Navajo can do anything with his hands that he has to do; the Apache, the same. If they could learn these skills while they are in school—we teach them the ABC's, that our God is the best God, that our culture is better than theirs. That is as wrong as wrong can be. I just offer that as something to think about.

Thank you very much.

Senator DeConcini. Thank you, Senator Goldwater, for opening the hearings this morning. I appreciate the participation. I had to sleep in. You young guys are up early, but I appreciate it.

Our next witness is the Chemehuevi Indian Tribe, Martha Wetmore, chairperson. Is Martha here?

Ms. Wetmore. Here, Senator.

Senator DeConcini. Your statement is of considerable length. We will put it in the record and if you could help us timewise by summarizing it, please, that would be very helpful.

STATEMENT OF MARTHA WETMORE, CHAIRMAN, CHEMEHUEVI INDIAN TRIBE

Ms. Wetmore. Senator, my name is Martha Wetmore, chairman of the Chemehuevi Indian Tribe.

I would like very much to be able today to present a report, either filled with statistics to prove our need for additional health resources, or to unveil some brilliant ideas on how to manipulate or reorganize the Indian Health Service in order to save enough money elsewhere to purchase the health care we need. I can not do either one. After I finish, which will be shortly, I believe you will understand why.

Historically, the Chemehuevi Tribe was a nomadic people living close to the earth in the desert lands ranging from what is now southernmost California up along the Colorado River and into southern Nevada. Over the course of years, and as a result of the United States western expansion, our lands were taken from us. It was only in 1976 that we received some parts of our lands again, and the process is still incomplete today. Beginning in 1970, our tribal members, who had been dispersed throughout the Southwest, began returning to Chemehuevi Valley. This also continues even as we sit here, but is severely limited by the lack of housing, health services, and employment to make possible even a basic living condition.

The Chemehuevi Reservation now consists of approximately 30,000 acres of land on which currently live one-fourth of my people for which I am responsible. Our numbers have swelled rapidly in the past few years, and we expect them to continue to grow as our people return to live together.

Although Lake Havasu City, home of the London Bridge and a town of 17,000 can be easily seen from most of our homes, we are effectively isolated on one side by Havasu Lake, which is over 4 miles wide, and several hundred miles of the Mojave Desert on the other side. There are no commercial boats or bridges to Lake Havasu City, so the services there are only to tantalize, not serve us. Unfortunately, because of the isolation, the brilliant blue lake fails to generate significant revenue for us. We have no industry or mineral wealth, so our tribe does not share the good fortune of an excellent income with some of the larger tribes in Arizona. No public transportation, either by water or by land is available, and many of our people are without transportation except for their legs. Winters are beautiful and mild and summers are relentlessly sunny and hot. The uninitiated would find the summers unbearable. We do not.

The health services available to our people are reminiscent of that provided to rural Americans perhaps 20 or 30 years ago. One doctor floats across the lake, once a week for 4 hours, if the weather permits, to provide outpatient services with the help of our one community health representative, the only health professional employed on the reservation. They care for patients in an old building without heat, with almost no diagnostic equipment and with few medications. Unfortunately, our people's illnesses occur more often than on Friday afternoon.

There is no emergency medical service, no E.M.T., and no ambulance within 50 miles. The nearest outpatient care, except for part of 1 day a week in our clinic, is at Parker, 70 miles away and across some of the hottest and most unpopulated desert in the United States. Parker is also the place we must go for our dental and other hospital care. I have already mentioned that we have no commercial transportation. In addition, our CHR is prevented by the Indian Health Service from transporting all but the most severe emergency cases, which she does by using her personal vehicle. Realistically, she cannot always be present for emergencies. She is not trained to treat all emergencies. Even if she could, it would not be possible to drive and treat a patient at the same time.

Our tribal government does not have the resources to purchase even a necessary item such as a vehicle. The present budget only provides for routine governmental functions on a day-to-day basis. We simply do not have reasonable access to health care, and it concerns me very much.

We have just a taste of community health services, nutrition, community health nursing, and social services. Just enough service to allow us to realize what we are missing. A half-day's service once a month for each of the areas is maximum. Some months we receive none at all. Since we are a small tribe, we cannot afford the services of a health planner or health coordinator. The rest of us are not health specialists, and we are unable to find resources from other than the Indian Health Service, if in fact any exists for us.

Since we have so little, it may seem strange that we could miss it at all if our health services should be taken away. You must understand that, because we do have so little, we must rely on what services we receive. IHS contract health service cuts may totally eliminate our primitive half-day-a-week clinic. The Parker IHS hospital may very likely be closed due to budget reductions. Categorical budget cuts will probably eliminate or drastically reduce the sprinkling of community health services we are now enticed with. IHS dental cuts may eliminate both our sources of dental care 50 and 70 miles away. We stand to lose it all.

I wish this meeting could have been held on the Chemehuevi Reservation so that we could make my words today really live in your minds. In fact, I wish that I could see inside your minds and that of other elected officials because I am confused. We are told that our health care is the responsibility of the Federal Government, and yet what little we have is slipping away. Has the Federal Government cast us like a flat rock on the water to skip into the air several times and finally sink to the bottom. What are we to do for health care?

I am not a health expert, whatever that is, but I do know that some of my people will become sick this year and not receive anything close to the same kind of medical care others in our country demand. We will have emergencies and people will die or be permanently injured because there is no emergency care. We are small in numbers and votes and probably of little concern as a result, but to each Chemehuevi his or her health care and life is just as important as yours is to you.

In closing, we would like to offer you an open invitation and a challenge. The invitation is to visit our land and learn firsthand both the beauty and the harshness of our lives. The challenge is to make what you and I are doing this day more than an instant replay of the Federal Government's relationship with native Americans. We challenge you to reach beneath the papers, politics, and media hype, to touch the hearts of human beings and make the only real contribution. That is to help where help is truly needed.

Thank you.

Senator DeConcini. Thank you very much, Ms. Wetmore. I appreciate your statement. I think it is very attuned to the questions I was going to ask you. You answered it very well, and that was what impact the loss of community funds have to the tribe. First of all, you have pointed out that you do not get much now, and if this community health representative program is eliminated, you would have nothing for your people, in essence.

Ms. Wetmore. That is correct.

Senator DeConcini. Quite frankly, the purpose of this hearing is to educate us as well as build a record. I was not aware that the distances for your tribe were so great. I must confess that I have not visited your tribal area. I have visited Lake Havasu, and it has been pointed out to me across the lake, and I would like to take some time and accept your invitation. I think the challenge is there for us to employ, and I use the word "minimal," because that is all we are talking about.

I thank you for your comments, and they will weigh heavily with both Senator Goldwater and myself.

Senator Goldwater.

Senator GOLDWATER. Thank you very much for being with us today. What percentage of the Chemehuevi Indians live down near Parker compared to the other side of the river?

Ms. WETMORE. The reservation is not in Parker.

Senator GOLDWATER. Do the Chemehuevi live around there?

Ms. WETMORE. Yes; our members are scattered throughout.

Senator DECONCINI. Is Parker the only help that you have?

Ms. WETMORE. Yes, Parker or the Phoenix Indian Medical Center.

Senator GOLDWATER. How many years has it been since there have been any improvements to the hospital?

Ms. WETMORE. Sir, I do not know of any improvements. I could not mention that.

Senator GOLDWATER. I think this tribe, Mr. Chairman, probably more than any other we will find in our State, typifies the extreme of this problem. While a few of the tribe's members live around Parker and there is a hospital available to them, most of them live where they have always lived, on the other side.

I would like to ask you one question. Are you still making those nice little baskets?

Ms. WETMORE. Very few people are making baskets. They no longer have the willows to make the baskets.

Senator GOLDWATER. I have a wonderful picture I took of an old Chemehuevi making a basket. I get more demands for that picture than any I have ever taken.

Thank you very much for being with us.

Senator DECONCINI. What is there for the population on the Chemehuevi Reservation? Are they involved in farming? Do you have any tilled soil or irrigation?

Ms. WETMORE. Not at the present time.

Senator DECONCINI. Do most of the people leave the reservation for work?

Ms. WETMORE. Yes, we are now in the process of reestablishing our reservation. The people are finally coming home.

Senator DECONCINI. What are they finding there to do?

Ms. WETMORE. Nothing.

Senator DECONCINI. Is it largely a retiring community? Or are your young people coming back, too?

Ms. WETMORE. Everyone is coming back. But then, again, they have to leave because there is nothing there for them.

Senator DECONCINI Thank you very much, Ms. Wetmore. We appreciate your fine testimony.

The next witness is the Indian Health Corporation/Indian Health Advisory Board, Perry Sundust, chairman.

Senator GOLDWATER. Mr. Chairman, I am sorry. I must leave.

Senator DECONCINI. Thank you, Senator Goldwater, for being here today.

Mr. Sundust.

Mr. SUNDUST. I would like to make this brief, a summary, and you have my copy of the testimony.

Senator **DeConcini**. We will put it in the record in full following your oral testimony.

STATEMENT OF PERRY SUNDUST, CHAIRMAN, PHOENIX SERVICE UNIT INDIAN HEALTH ADVISORY BOARD

Mr. **Sundust**. My name is Perry Sundust, chairman of the Phoenix Service Unit Indian Health Advisory Board. We call ourselves the medical service board, and we do change names and titles.

I assume that everybody knows now the problems we are facing if budgetary cuts go into effect where the Indian health service is concerned, and I think the critical need that, especially the medical center, is facing now is a shortage of staff and equipment and drugs and everything so we recommend some few changes that would be eliminated in the medical center.

In summary, I would like to bring to your attention the following recommendations: No. 1, legislation must be introduced to bring about the changing of Federal rules and regulations, and Federal policies and procedures, which at the present time impede the adoption of appropriate and practical managerial decisions by the Phoenix area IHS; the Indian health service, at a certain level; that of hospitals and field clinics, as well as other levels. Such major measures should be designed to magnify the existence of the resources of the health services.

No. 2 introduces legislation to promote the remedy of utilizing appropriations as well as other available resources such as health insurance and medicare. At the present time there is an excessive number of revisions in the rules and regulations that do not permit flexibility in the tribal organizations. These, in summary, are the recommendations.

To provide some background on the issue: The Federal regulations for the Indian health service create an extremely cumbersome system, a system of rules and regulations where service units are forced to use contract health dollars to purchase services from institutions outside the IHS system. Due to this inflexibility of Federal policy and procedure, IHS service units have a very difficult time implementing important decisions relating to their day-to-day operation. At the present time service units, such as the Phoenix Indian Medical Center, cannot adopt timely measures to cope with the shortage of critical personnel or the need for essential equipment. Even if funds have been budgeted for these items PIMC must initiate procedures which require reviews and approval by the Phoenix area office. At the present time IHS service units are not motivated to bill insurance carriers because every dollar collected would have to be surrendered to the U.S. Treasury. This is a typical and not intelligent method of delivering health service.

The issues and the remedies are as follows: Legislation must be introduced to change restrictive Federal rules and regulations. The Phoenix Indian Medical Center and other service units should be given autonomy on all matters relating to their operations. This would include control of their own budgets. There also should be tribal involvement in some cases.

An appropriate environment for profitable joint ventures between tribal organizations and IHS does not exist. There is an absence of mechanisms which would allow the creation of revenue-generating ventures similar to those created by nonprofit, private health institutions. I think it would ease the shortage of what we are facing now if there were a lot more involvement of the tribe and more input.

Senator **DeConcini**. Thank you very much, Mr. Sundust.

Let me pursue one thing you talked about; the need for autonomy on matters relating to their operation. I want to be sure you are not suggesting that block grants would be the answer, are you, or are you indicating that that might give you some autonomy? I would like to clarify that matter.

Mr. **Molleda**. My name is Edgar Molleda. I am the director of the corporation which is headed by Mr. Sundust. The vision of autonomy is basically one of managerial autonomy. I am talking about the mandated rules and regulations that are handed down, which make the IHS system an extremely cumbersome system. In the written statement there are examples, for example, of replacement of the equipment or the hiring of personnel. Before a critical position, such as a nurse, can be replaced at the Indian medical center, I have to go through a number of approvals at the local area office and eventually the headquarters.

Senator **DeConcini**. In the meantime can you hire the person temporarily?

Mr. **Molleda**. There are some waivers, but the process is always extremely slow. If you go to the average community hospital, a hospital in any community, those situations are handled and decisions are made in a very short period of time. It may take 1 day or 2 days to make those decisions. In the meantime patient care continues.

Senator **DeConcini**. So you are saying if you could get these decisions made at the medical centers or at the hospitals, even if you have certain budget limitations, the problem is that some of the elementary decisions could be made by the board or by the executive director or in conjunction with going someplace else for other health care service delivery?

Mr. **Molleda**. Precisely.

Senator **DeConcini**. Thank you, Mr. Sundust.

[The prepared statement follows:]

PREPARED STATEMENT OF MR. PERRY SUNDUST, CHAIRMAN, PHOENIX SERVICE UNIT INDIAN HEALTH ADVISORY BOARD, INC.

SUMMARY

The Phoenix Service Unit Indian Health Advisory Board recommends the following:

(1) That legislation be introduced for the purpose of changing Federal policies and procedures which at the present time impede the adoption of appropriate managerial measures by Indian Health Service officials at the Service Unit level (hospital and field clinics) as well as other levels. Such measures should be designed to maximize existing resources for provision of health services.

(2) Introduce legislation to promote creativity in the utilization of IHS appropriated funds as well as available resources such as health insurance and medicare. At the present time there is an excessive number of restrictive rules and regulations that do not permit creative approaches by IHS officials or tribal health organization.

Senator DeConcini and committee members, my name is Perry Sundust. I am the Chairman of the Phoenix Service Unit Indian Health Advisory Board.

This Board is composed of representatives from seven central Arizona Tribes. The primary roles of this organization are: (1) to manage innovative health services, and (2) to communicate and advise the Phoenix Indian Medical Center on the needs of the institution's service population. I would like to present today a few concerns of the organization I represent. I would also like to offer recommendations for legislative or executive actions. The present policies of the Federal government are damaging the health systems which provide services to all American people. However, the damage to the system which serves Indian people is greater than expected and will have a long lasting effect. The budgetary cuts being implemented by the Reagan Administration do not make provisions for a rational approach in the reduction of expenditures for health services. Consequently, vital services are bing jeopardized haphazardly, unwisely, and in a very destructive manner.

For the sake of brevity and expediency, since other Tribal groups and governments are addressing a number of issues at this hearing, I would like to discuss only two issues relating exclusively to Indian Health Service management policies and procedures which are bound to a large extent by cumbersome Federal regulations. I would also like to recommend solutions aimed at maximizing existing resources.

ISSUE NO. 1

Federal rules and regulations force the Indian Health Service to create an extremely cumbersome decision-making system.

BACKGROUND

Due to inflexible Federal policies and procedures, IHS Service Units have great difficulty in implementing simple, but important decisions in their daily operations. At the present time, Service Units such as the Phoenix Indian Medical Center (PIMC), cannot adopt timely measures to cope with shortages of critical personnel or the replacement of essential equipment. Even if funds have been budgeted for these line items, PIMC must initiate an approval process which requires review and approval by the IHS Phoenix Area Office and eventually by IHS Headquarters on the other side of the continent. This is definitely not an intelligent method of delivering health services.

RECOMMENDATION NO. 1

Legislation must be introduced to change Federal rules and regulations which impede the adoption of appropriate and practical managerial decisions by the Phoenix Area IHS and by each Service Unit.

Specifically:

(*a*) The Phoenix Indian Medical Center (PIMC) and other Service Units should be given autonomy on all matters relating to their operations. This would include control of their own budgets.

For example, PIMC must be allowed to recruit and hire critical personnel (nurses, physicians) without approval from Headquarters or the Phoenix Area Office, providing that the hospital does not exceed a negotiated annual budget. In order to maintain and deliver quality services, the hospital and the various Service Units must be given flexibility along with the appropriate authority and responsibility.

(*b*) Similarly, the Phoenix Area Office of IHS must be given complete autonomy from Headquarters on matters which pertain to activities of the Phoenix service area. This arrangement would permit delegation of authority and responsibility to all Service Units.

ISSUE NO. 2

The cumbersome Federal system does not permit creative approaches in the maximization of existing resources or the utilization of available resources other than those appropriated exclusively for the IHS operations.

BACKGROUND

Restrictive policies create situations where IHS personnel are not motivated to maximize their existing resources in creative ways. Due to a cumbersome system of rules and regulations, Service Units such as PIMC are forced to use contract health dollars to purchase services from institutions outside the IHS system. IHS employees are also inhibited in developing the necessary knowledge and sophistication which would permit them to tap other resources such as health insurance programs. At the present time, IHS Service Units are not motivated to bill insurance carriers because every dollar collected would have to be surrendered to the U.S. Treasury.

An appropriate environment for profitable joint ventures between tribal organizations and IHS does not exist. There is an absence of mechanisms which would allow the creation of revenue generating ventures similar to those created by non-profit, private health institutions. Contract health dollars could be channeled to tribal enterprises created with the help of IHS. Profits made by these tribal organizations could be used to maintain services.

RECOMMENDATION NO. 2

Legislation must be introduced to change restrictive Federal rules and regulations for the purpose of promoting creativity in the utilization of available resources.

Specifically:

(*a*) There is an urgent need to design a system which will motivate IHS personnel to capture all health resources. A mechanism should be created to allow each Service Unit to retain every dollar collected.

(*b*) There is an urgent need to promote the creation of cooperative relationships between IHS facilities and tribal corporations for the purpose of establishing revenue generating enterprises. Tribal corporations could play the role of subsidiary and/or for-profit corporations whose sole purpose would be to maintain and improve IHS services.

(*c*) Greater emphasis must be placed upon the transfer of IHS programs to tribal organizations which wish to assume responsibility for such programs. It is imperative that artificial barriers be lifted in order to permit such transfers.

Senator DECONCINI. Our next witness will be Mr. John Wise, director of the Native Americans for Community Action.

STATEMENT OF JOHN WISE, DIRECTOR, NATIVE AMERICANS FOR COMMUNITY ACTION ALCOHOLISM PROGRAM, FLAGSTAFF, ARIZ.

Mr. WISE. Good morning. My name is John Wise. I am currently the director for the Native Americans for Community Action alcoholism program, located in Flagstaff, Ariz. I also held the position of director of the Hualapai Mental Health Clinic in 1979. My experience with these programs and as a counselor/therapist with other programs in northern Arizona has given me the opportunity to gain some knowledge of the administration and service delivery problems associated with Indian health, particularly as they apply to alcoholism treatment.

The Native Americans for community action alcoholism program is an outpatient treatment program designed to provide family, group, and individual counseling and prevention service to Native Americans experiencing problems associated with alcoholism and alcohol abuse. Since Flagstaff borders the Navajo Indian Reservation, 90 percent of our clients are members of that tribe.

In order to respond to your request concerning the impact of program reductions on Indian health, I think it is important to outline some of the extent of the problems asociated with alcoholism as it applies to members of the Navajo Tribe.

The health status data indicates that out of the 10 causes of death among Navajos, five are related to alcohol use, and they are: chronic alcoholism, cirrhosis of the liver, homicides, accidents and suicides.

The Indian Health Service estimates that 75 percent of accidental deaths and 65 percent of all fatal motor vehicle accidents are alcohol-related. The Navajo death rate from alcoholism, excluding deaths due to cirrhosis, kidney failure, pancreatic disease, exposure, and accidental causes, is over five times the United States average. Cirrhosis of the liver accounted for 4 percent of Navajo deaths as compared to 1.7 percent of the total U.S. population. Homicides accounted for 3.9 percent of all Navajo deaths. The Indian Health Service estimates that 90 percent of the homicides committed in Indian communities occur while either the perpetrator or the victim is intoxicated. Suicides account for 1.5 percent of Navajo deaths, and it is estimated that 80 percent of all Indian deaths by suicide are alcohol-related.

In view of this information it is difficult to suggest any program cuts without impacting Indian health.

The program that I direct and many other treatment programs funded through the Phoenix area office are currently trying to adjust to previous budget reductions. Any further reductions in the Native Americans for community action program funding would have to come in the form of staff reductions. The entire alcoholism program staff now consists of only three persons. The loss of one employee would mean that direct services would be reduced by one-third, or the denial of services to 55 clients now receiving counseling through our program.

Funding reductions already in effect have seriously reduced the effectiveness at the area office level. Travel and staff reductions in administration have eliminated the ability of the area project officer to assist in the development, evaluation, and monitoring of individual programs. Time and personnel needed to accomplish these tasks are not used exclusively to review and implement funding for annual proposals. The result is a situation in which 20 individual alcoholism treatment programs are dependent in varying degrees on valuable assistance from an area office staffed with one person with no travel funds. I might add that these programs are spread over an area covering four States. Any real monitoring of these programs have been eliminated. Individual programs are now required to perform in-house evaluations. This system does little to inform the Indian Health Service, because it is really a form of grading your own test. Obviously, program directors are hesitant to risk cutting their own funds or their entire program by submitting a poor evaluation.

Perhaps, the most damaging effects of administration funding reductions is associated with the implementation of the Indian Health Service Alcoholism Treatment Guidance System, an innovative system designed to standardize treatment for all Indian Health Service alcohol programs. This development would allow, for the first time, some degree of centrality and common purpose to the task of impacting Indian alcoholism. Valuable information produced by this system would allow individual project directors and Indian Health Service planners to develop continuity and secure client follow-up information desperately needed to implement effective overall intervention. Because of administrative funding reductions, all the individual client reports submitted by the programs within the Phoenix area since July 1—15,000 in all—cannot be analyzed or processed. Therefore, the Alcoholism Treatment Guidance System, the basis of treatment for Native Americans suffering from alcoholism, is now useless.

I hope that this brief review of some of the problems associated with budget reductions has been helpful to you. I would like to make some recommendations that I feel are essential for the provision of service to impact the overwhelming problem of alcoholism in this area.

First of all, the Indian Health Service area office should take the responsibility for providing centralized leadership and program development for programs funded through their agencies. Training, referral networking, individual program development, monitoring and evaluation should be implemented by the area office based on a concept of interdependence. Significant funding should be made available to the area office to insure effective compliance with these responsibilities. Future funding reductions should be based on the ability to impact the problem of alcoholism and should be determined by area office evaluations and site visits. Program evaluation criteria should be based on the ability to meet administrative, program, and case management standards as outlined in the IHS site visit protocol, 1982, and a standardized success rate as defined by the Indian Health Service.

In conclusion, I feel that I must point out that these statements and recommendations do little to describe the overwhelming suffering by native Americans who are devastated by this terrible disease, or the overwhelming feeling of frustration experienced by program directors and their employees who have for years responded to this challenge with the puniest of resources.

In 1979 I was the director of the Hualapai Mental Health Clinic in Peach Springs, Ariz., a community devastated by a 65-percent alcoholism rate among adults. This community of 900 persons was without a real work force. Although there were several Government and tribal work incentive programs, absenteeism was so high that there was no production or skills development by employees. The social makeup of the community was so influenced by alcoholism that those persons that wished to remain sober were isolated. One of my clients who had managed to stay sober for a short period finally gave in to peer pressure in the form of anonymous gifts of whisky periodically left on her doorstep.

There was a LARC center in the community, but it was staffed by practicing alcoholics who happened to be sober for a few days. Many times counselors would accompany clients on extended drinking binges. On several occasions tribal police were required to intervene because drinking parties were being held at the LARC Center.

Instances of assault, rape, homicide, and suicide were commonplace. In a 3-month period I evaluated 21 suicide attempts requiring hospitalization, for a community of 900 people. Three boys in one family had attempted suicide in a period of 2 weeks. At that time the Hualapai Mental Health Clinic consisted of myself and a secretary/counselor trainee.

I have a haunting memory of my experiences on the Hualapai reservation. That memory is of an elderly Hualapai lady repeatedly asking me and reminding me that I was supposed to help her people and asking why her sons did not get better and why they attempted suicide. I did not have an answer for her. I can, however, remind this commmittee of these issues and suggest that they supply the answers.

I appreciate the opportunity to express my opinions and offer recommendations to this committee and I will be happy to give any additional assistance that may be requested of me. Thank you.

Senator DECONCINI. Mr. Wise, thank you for your moving testimony. Obviously, the answer is not to reduce the funding that is there. Let me ask you this. If we continue with the minimal funding, and let us assume there were no reduction in the funding, if we continued the funding, are we instead providing anything but new frustration in not giving sufficient care and medical attention? I am not suggesting that this is what we should do. I am just seeking advice from someone who has been on the front line.

Your testimony points out how poor the Hualapai clinic services were, and that is not a discredit to you because of the lack of resources. Yet, I wonder, if we do not make increases, if we really do anything more than cause more anxiety and more frustration, and maybe instead of alleviating the suicide and alcoholism problem we are exciting and inflaming it. Would you comment, please.

Mr. WISE. I think, based upon the recommendations that I made, that a more centralized effort out of the area office would help to alleviate some of those problems by monitoring and evaluation of individual programs that may not be fulfilling their responsibility to the Indian Health Service, that maybe their contracts be reviewed, and if it is found that they need to be cut, the cut would go to the central office and the money put to better use.

Senator DECONCINI. So you are suggesting that close scrutiny of all of these programs ought to be had, and if, in fact, there are no more fnnds, then we must conclude, reasonably, that some should be shut down and others, where a better job is being done, should be given the resources?

Mr. WISE. Yes.

Senator DECONCINI. And what appears to be a shotgun approach may be very faulty in its delivery of services, is that a fair summary?

Mr. WISE. Yes, and along with the assumption, first, that we can't—I am not recommending the cuts in the first place.

Senator DECONCINI. I understand your position very clearly, and I am not suggesting that we cut either. My point is, if we can see where we are, whether we are doing a disservice, and what you are saying to me, if I understand it, is that we should carefully scrutinize these programs, and if they are not providing any benefits, then those resources should be cut and they should be delivered some place where they can provide the benefits.

Mr. WISE. Based on the interdependence of all programs. For instance, if there is a specific urban or reservation program that did not meet any Indian Health Service guidelines, had trouble providing impact in the community, possibly this could be assisted by another program or it would come under the authority of another program somewhere else that was more efficient in providing that health care. The programs helping each other is what I am trying to do.

Senator DECONCINI. I understand. Thank you very much, Mr. Wise.

Our next panel of witnesses, is from the Indian Health Service: Mr. Joe Exendine, Richard Hammond, and George Blue Spruce.

Gentlemen, if you will, please come forward and introduce yourselves.

STATEMENT OF DR. JOSEPH EXENDINE, ACTING DIRECTOR, INDIAN HEALTH SERVICE, ACCOMPANIED BY DR. RICHARD HAMMOND, CHIEF MEDICAL OFFICER, NAVAJO AREA; CHARLES ERICKSON, ACTING DIRECTOR, TUCSON PROGRAMS OFFICE; AND DR. GEORGE BLUE SPRUCE, PHOENIX AREA OFFICE

Dr. EXENDINE. Mr. Chairman, I am Dr. Joseph Exendine. I appreciate the opportunity to testify here this morning. With your permission, I would like to summarize the statement.

Senator DECONCINI. Thank you. We would appreciate that.

Dr. EXENDINE. On my far left is Dr. Richard Hammond, the Chief Medical Officer of the Navajo area. On my immediate left is Mr. Charles Erickson, who is the Acting Director of the Tucson Program Office, and on my immediate right is Dr. George Blue Spruce, Director, Phoenix Area Office.

As you know, Mr. Chairman, the Indian Health Service represents approximately 865,000 eligible American Indian people and Alaska natives. In addition, limited health services are provided in 41 urban locations. Of the 41 urban projects two are in Arizona and one each is in Nevada and Utah. The fiscal year 1982 budget for the Indian Health Service is $646.8 million, a decrease of $42.9 million from the 1981 level. The budget includes $599.6 million for Indian health services and $47.1 million for Indian health facilities.

We have just recently received the approved apportionment of this appropriation and, therefore, I am unable to provide a definitive breakdown of the specific impact on the Phoenix, Navajo, and Tucson areas. However, I can provide the national breakdown of the budget on page 2 of this statement. I will not go through it here.

The 1982 budget for Indian health services includes funds to staff and operate several new facilities selected to open in fiscal year 1982 and to serve newly recognized tribes.

Mr. Chairman, that concludes my opening remarks. At this time I will be happy to answer any questions you may have.

Senator DECONCINI. Mr. Exendine, on page 2 you list the fiscal year 1982 appropriations for health service. Have you had an opportunity to review what has been proposed by the administration for 1983 and do any comparisons?

Dr. EXENDINE. Yes, we have.

Senator DECONCINI. Do you have that, by any chance, or could you give us that and save us the time?

Dr. EXENDINE. I would be more than happy to supply that for the record.

Senator DECONCINI. Can you give me a brief overview, tell me the changes or whatever reductions we are talking about here?

Dr. EXENDINE. Let me take you quickly back here. The fiscal year 1982, on the originally revised budget that came out in August, was $646.8 million, and then late in September, the First Continuing Resolution, as you are well aware of, put us back to the 1982—actually the 1981 level, which is $606.7 million. However, we had instructions from the OMB to function at the 10-percent level, and we did. In 1981, over several months, we have been operating at $599.6 million.

Senator DeConcini. So you did comply with that.

Dr. Exendine. However, the guidelines that came out of OMB—and I am happy to say they did not give particular instructions on how that 10-percent cut should be administered. If you recall they had cut out the CHR program and the urban program, so I chose to, rather than zero out of those two programs, I chose to take and continue them on a 30-day basis, 30 days at a time to keep them going until we found out exactly what was going to happen.

Senator DeConcini. We are able to do that?

Dr. Exendine. Throughout the year, so far, and until the Third Continuing Resolution. Then, we had to operate at the 17-percent level, and then in the December 16 resolution we had to—it would be February 1, we had to operate at a 21-percent level.

Senator DeConcini. 21 percent below the 606 figure?

Dr. Exendine. Below—actually the $36 million. that was in 1981. The reason for that rationale, we complied with what the conference committee came out with and we used that as a guide. We did not want to zero out the CHR program nor the urban program for 1983.

Senator DeConcini. Now, do you think you will have to do that?

Dr. Exendine. If there is no money in the fiscal 1983 budget for those two programs.

Senator DeConcini. I notice in the estimate here that approximately 865,000 eligible American Indian people and Alaska Natives are living on or near Federal Indian reservations or in traditional Indian country such as Oklahoma and Alaska and that limited health services are provided in 41 urban locations having an Indian population estimated at 300,000, half of whom are included in the 865,000 figure mentioned earlier. That is a startling bit of information to me

Dr. Exendine. Yes, sir, it is.

Senator DeConcini. And I can see how you arrived at that judgment, and I applaud your efforts to continue the very minimal urban health funding that you did up to this point, and I can assure you that this Senator will do all he can to continue those fundings. Your figures make the whole case for us.

Let me ask Dr. Erickson or Dr. Blue Spruce: You operate the centers here in Arizona, in Tucson and in Phoenix; is that right? You operate the one in Tucson?

Mr. Erickson. Yes, sir.

Senator DeConcini. That is in the city?

Mr. Erickson. No, sir, the area office is located on the reservation.

Senator DeConcini. I did not know where it was. I have lived there all my life.

And where is your center?

Dr. Blue Spruce. We are at the Phoenix Area Indian Health Service Administrative Office, so we are responsible for a 3-State area.

Senator DeConcini. What is the increase in cases that you are having here in Phoenix from their coming to your facility. Do you have any figures on that? Is that up over last year?

Dr. **Blue Spruce.** Oh, yes, the Phoenix metropolitan area tends to be an attractive location for a lot of people to settle, and that includes Indians, and right now our figures range anywhere from 12,000 to 17,000 at any particular period.

Senator **DeConcini.** What kind of increase is that? Can you give us any estimations over last year or 2 years ago?

Dr. **Blue Spruce.** Over a couple years ago that is upward of 30 to 40 percent.

Senator **DeConcini.** From, say, 1978?

Dr. **Blue Spruce.** That is correct. Yes; we were recording 5,000, 6,000 back then, and now you can take the figure of 17,000, 18,000 in the metropolitan area alone, which does not include the urban Indians in Utah and Nevada, which make it upward of 30,000.

Senator **DeConcini.** And how about the Tucson area? Do you witness the same thing?

Mr. **Erickson.** Yes, sir, in obstetrics, in particular, in the hospital in Sells, we have had a 40-percent increase in cases that we have handled in the hospital this fiscal year thus far.

Senator **DeConcini.** This year over last year?

Mr. **Erickson.** Yes. And for the Yaqui program the population is not yet stable. We are experiencing about 30 new enrollments every month since they have been recently recognized.

Senator **DeConcini.** So these cuts that appear to be coming down in 1973 are going to crimp your operations severely?

Mr. **Erickson.** And we have also had a rather dramatic increase in Indian utilization of the urban clinic in Tucson in the last several months.

Senator **DeConcini.** Dr. Exendine, did I hear you recommend to eliminate the funding for the community health representatives program, or was that OMB?

Dr. **Exendine.** No, sir, we did not recommend it at all.

Senator **DeConcini.** That was done outside your jurisdictional area or outside of your professional suggestions.

Dr. **Exendine.** Yes, sir.

Senator **DeConcini.** Is that safe to say?

Dr. **Exendine.** Yes, sir.

Senator **DeConcini.** I am really disturbed to see these drastic cuts coming. How long will you be able to continue these services in the community health program and in the urban Indian programs; through this fiscal year we are in or do you anticipate—is that why you have kept it on the 30-day operative base?

Dr. **Exendine.** Yes; actually since the early—a year ago we have been under what you call a personnel freeze, and that enables us to free up some money. Of course, we cut back on travel and administrative travel and transportational and things along that line that enables us to maintain that program as much as we could, and what we tried to do, we tried to maintain the CHS program at the 646.8 level.

Senator **DeConcini.** Going back to the Continuing Resolution with the mandated—was that the 17-percent reduction, if I understand your figures here? Was that equally distributed?

Dr. **Exendine.** We prorated it.

Senator DeConcini. In other words, the administrative parts of the CHS received a 17-percent reduction of the programs?

Dr. Exendine. Just in the CHR programs, and we have actually taken—the majority of the programs—it was a 10-percent cut. What we ended up doing, again, we prorated that, based on the number of CHR's in each area.

Senator DeConcini. But did that affect the administration as well as the program in the area offices?

Dr. Exendine. It had an impact on the CHR programs, yes; it did.

Senator DeConcini. Do you have a question?

Mr. Richtman. Joe, to what extent does IHS contract in the Phoenix area? Do you know?

Dr. Exendine. No; I can give you a national average as far as CHR programs. I can give you figures on the national level. It is around $135 million, our program.

Mr. Richtman. We have been told that, again, October 1, the IHS will be required to go into competitive bids and contracts; is that correct?

Dr. Exendine. We have had instructions that we should start looking closer at competitive bids. We have had a method of not competing for bids in the system, and they recently reinstituted that.

I have some problems with that, particularly in some isolated areas where we have one physician. It would be very difficult to go out and get competitive bids, and I think the feeling is it may somewhat jeopardize the quality of care. If you have only one or two physicians in the location, you may not get the best physician to employ the quality of care for the people that you would like, but there are some provisions that enable us to not go out on competitive bids if we can just live with them.

Mr. Richtman. Well, it is our understanding, from talking to John Kelso at the Health Service Administration, that beginning October 1 the IHS is going to be mandated to go to competitive bids in its contracts. Is that a directive or just a suggestion?

Dr. Exendine. It is under discussion.

Mr. Richtman. So, it has not been decided?

Dr. Exendine. No, sir.

Senator DeConcini. Mr. Exendine, if I may ask you a question. When OMB comes down with this, and I understand the sensitivity of fighting with OMB, when they come down to eliminating the community health representative program, do they give any justification for, say, wiping that out?

Dr. Exendine. Most generally, it is a message that comes down.

Senator DeConcini. Do you have a right to appeal at a lower level of OMB?

Dr. Exendine. What do you mean by a lower level of OMB?

Senator DeConcini. The directive that comes down.

Dr. Exendine. No; we send our field representation to Health Services Administration. It goes to Public Health and then into the Department.

Senator DeConcini. You do not get a chance to argue that with OMB?

Dr. Exendine. For the first time since I have been in Washington, D.C., we did not have OMB hearings.

Senator **DeConcini**. So those are cut and dried as far as your input or getting an opportunity to answer any questions.

Dr. **Exendine**. For the first time we do not.

Senator **DeConcini**. The reason I asked the question, I get the feeling that OMB has little or no understanding of what the Chemehuevi Tribe is going to face now. They think they have little or no health care and I concur with Ms. Wetmore that they have barely minimal care, if you could call it that. I wonder if OMB knows they are going to have absolutely no care and no one was there to even explain that to them. Is that a fair statement that you or none of your representatives ever have had an opportunity to explain that to OMB, particularly?

Dr. **Exendine**. Not in this particular year, we did not. I might add my own personal opinion. I think the CHR program is an exceedingly good program. I personally hate to see it zeroed out from the standpoint that we could have the best physicians in the world in our facilities, but it provides us with a link to the community that we would not have otherwise. They are able to identify all the small children in the local community. A good many of them are AMS technicians who are able to respond quickly to accidents, for example, and that eliminates a great deal of trauma and stuff which actually cuts down on medical care, whereas, generally, on an average it takes about 2 to 3 hours for an individual to get to the hospital. They can provide the initial care on an accident in 15 or 20 minutes. We have about 1,000, right now, of CHR's who are actually specialists, audio specialists, things along that line, and they provide excellent service.

Dr. Blue Spruce.

Dr. **Blue Spruce**. It was the community health representative program that was the true forerunner of Indian self-determination at the community level. It was they who for the very first time carried the flag in terms of true community involvement in their health program, but one of the direct offshoots of it has been something that I think most people overlook. It was the mothers and fathers who were the first community health representatives to get sensitive to the needs of health care, to understand the importance of the health delivery system, and now more than ever you see their offsprings pursuing careers in health, which would, in turn, return a direct service back to the community. They have educated themselves in these various health careers and can come back to their respective communities and serve. I think that the community health representative program, if it is totally wiped out, disregards all of the direct and indirect impact that it has made.

Senator **DeConcini**. Thank you very much.

Max, go ahead if you want to ask questions of anyone else.

Mr. **Richtman**. The BIA is considering reorganizing the 11 areas into 5 regional offices on October 1. Is there any discussion in the Indian Health Service of similar transformation of area offices in your number of regional offices?

Dr. **Exendine**. Yes, because of the budget cuts we have to take a hard look at it, and we're considering it without any kind of decision being made. It is just under advisement now, perhaps, cutting down on some of the area offices, perhaps, consolidating some of the administrative services, and perhaps cutting down a great deal on some programs, staff people, and we are already taking steps now to cut down drastically on the headquarters-type personnel, and we have made some cuts. We are in the process of getting approval for that to happen this year because of budget cuts.

Thank you.

Senator DECONCINI. Gentlemen, thank you very much. I do not know what your time is, but these hearings are going to go on for a while. I have to leave at noon. We will continue with the hearings even after I leave to be sure we have a full record. I wonder if there is any chance that you might be here and available to answer some questions to either myself or the staff after we hear the testimony. I think we are going to have some suggestions that we'd like to pass off to you if any of you will still be around.

Thank you very much.

Your prepared statement will be entered in the record at this point.

[The prepared statement follows:]

PREPARED STATEMENT OF DR. JOSEPH EXENDINE, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee, I am Dr. Joseph Exendine, and I am the Deputy Director of the Indian Health Service. I appreciate the opportunity to testify this morning on the Fiscal Year 1982 budget of the Indian Health Service. I am accompanied this morning by Dr. George Blue Spruce, Director, Phoenix Area Office, Indian Health Service; Mr. Charles Erickson, Acting Director, Tucson Program Office; and Dr. Richard Hammond, Chief Medical Officer, Navajo Area Office, Indian Health Service. I am also accompanied by H. Frank Palone, Gary Ryan and Eva Gentry, the Financial Management Officers for the Phoenix Area, Navajo Area and Tucson Program Office respectively.

As you know, Mr. Chairman, the Indian Health Service represents the primary Federal health commitment to approximately 865,000 eligible American Indian people and Alaska Natives living on or near Federal Indian reservations or in traditional Indian country such as Oklahoma and Alaska. In addition, limited health services are provided in 41 urban locations having an Indian population estimated at 300,000—half of whom are included in the 865,000 figure mentioned earlier. The total Indian Health Service service population for the Phoenix and Navajo Area Offices and the Tucson Program Office is approximately 279,000. Of this total, approximately 160,000 live in Arizona, 14,000 live in Nevada, and 9,000 live in Utah. In addition, of the 41 urban projects 2 are in Arizona and 1 each is in Nevada and Utah. The Indian Health Service is constantly endeavoring to provide quality health care to these individuals, while always recognizing that the medical needs of Indian people demand a special measure of priority and attention from the Federal Government.

The fiscal year 1982 budget for the Indian Health Service is $646.8 million, a decrease of $42.9 million from the 1981 level. The budget includes $599.6 million for Indian health services and $47.1 million for Indian health facilities.

We have just recently received the approved apportionment of this appropriation and, therefore, I am not able to provide a definitive breakdown of the specific impact on the Phoenix, Navajo and Tucson areas. However, I can provide the following national breakdown of the budget:

Specifically, the fiscal year 1982 appropriation for health services includes:

$307,339,000 for hospital and health clinic programs.

$17,884,000 for dental health programs;

$7,488,000 for mental health programs;

$16,290,000 for alcoholism programs;

$8,267,000 for maintenance and repair;

$110,427,000 for contract care;

$14,090,000 for sanitation services;

$7,969,000 for public health nursing;

$2,194,000 for health education;

28,800,000 for the community health representation program;

$8,160,000 for urban health projects;
$5,760,000 for Indian health manpower;
$2,634,000 for tribal management;
$48,851,000 for program management; and
$13,492,000 for the Equity health care fund.

The 1982 budget for Indian health services includes funds to staff and operate several new facilities selected to open in fiscal year 1982 and to serve newly recognized tribes. The 48 Indian Health Service hospitals will provide services to approximately 82,000 inhabitants. In addition, the 48 outpatient departments, 98 health centers and the more than 300 satellite clinics will provide an estimated 3.4 million outpatient visits, approximately the same number of visits as the fiscal year 1981 level. Scholarships will be provided to approximately 500 Indian students for training in the health professions.

Mr. Chairman, that concludes my opening remarks. At this time I will be happy to answer any questions you may have.

Senator DeConcini. The next panel is the Colorado River Indian Tribes, and their chairman, Anthony Drennan, and Bob Crawford. Please come forward.

Would you identify yourself for the record, please.

Good morning, Mr. Chairman.

Mr. Drennan. Good morning, Senator.

Senator DeConcini. Would you introduce us to your colleagues, please.

STATEMENT OF ANTHONY DRENNAN, CHAIRMAN, COLORADO RIVER INDIAN TRIBE, ACCOMPANIED BY ELLIOTT BOOTH, TRIBAL SECRETARY, BOB CRAWFORD AND CAROLYN RIGGS, HEALTH DIRECTORS

Mr. Drennan. My name is Anthony Drennan. I am chairman of the Colorado River Indian Tribe. On my left is Elliott Booth, tribal counsel, member and secretary of the tribe, and on my right is our Colorado River Tribe health directors, Bob Crawford, and Carolyn Riggs.

We appreciate the time this morning that you are giving to us.

The Colorado River Indian Tribe Service Unit, a 20-bed hospital with outpatient service, in addition to the Colorado River Indian Tribes, serve the Chemehuevi, Fort Mohave, Hualapai, and Havasupai Tribes. This information is presented because many of the nonessentials such as travel are essentials at Colorado River. It also emphasizes the role of Indian Health Service as the primary health care provider to the Colorado River Indian Tribes.

Present health care resources are seriously inadequate and fail to meet the growing demands for quality care services. The basic facility which provides inpatient and outpatient services to our tribe and four other tribes within the service unit is a 50-year-old facility with deteriorated and obsolete equipment, space deficiencies, and layout problems. Only general and routine patient care is administered at this facility. In order to receive secondary and tertiary care, patients must be referred to the Phoenix Indian Medical Center, a distance of 350 miles round trip.

Presently, a facility feasibility study is underway to determine the current facility needs of the tribe. Replacement of the outpatient facility is top priority for the tribal health department. By the end of the fiscal year, the tribal health department in cooperation with Indian Health Service will have completed the study and begun to pursue the next steps toward constructing the new health facility, and that is with fingers crossed.

The impact of the Federal budget on the Colorado River health programs. I would like to point out the clinical services in fiscal year 1981, and in order to fully understand the impact, we must restate the fact that the service unit was already 40 to 60 percent underfunded beginning fiscal year 1981. All of the reductions seriously affect the ability to meet the basic health needs of the Colorado River Indian Tribes that use the facilities.

The specific reductions are to lapse two nursing positions. We had to return two GSA vehicles and lapse the service unit director's position for 9 months and had to lapse a physician position for 3 months. We have had a reduction in travel and have reduced telephone calls. However, it is essential to have contact with the Phoenix Indian Medical Center.

The effects on direct patient care are longer waits in the clinic due to physician and nursing shortages; the decline in nursing morale due to staff shortage and increased workload.

The fiscal year 1982 clinical services, a budget for the service unit has still not been received as of this date. However, based upon all information available, if we continue to operate at the fiscal year 1981 level, a deficit of $667,048 is projected.

The alternatives are limited, the effects on patient care devastating. By delaying the budget process this long, the impact of the deficit is doubled. To meet this deficit we are faced with the following options and projected savings: reduce community health service, lapse all vacancies and fire temporaries, and close inpatient services. The total is $1,004,550.

The option B has already been implemented, resulting in elimination of one physician position, prevention of the opening of the OB services, and the elimination of health education.

The options A and C will result in closure of all inpatient services; referral of all OB patients to Phoenix; elimination of dental services; elimination of all over-the-counter drugs and some prescription drugs; elimination of home health services, including community health nursing, nutrition, and social services; elimination of home health supplies; and reduction in environmental health services.

Fiscal year 1982 contract health care. A $100,000 deficit in contract health care was projected, which will require the following: contract health care payments for emergencies only; elimination of air transportation to Phoenix Indian Medical Center—transportation is now by van, 175 miles one way; elimination of medical and psychiatric care for emotionally and mentally disturbed patients treated in a nonmedical facility; and reduction in eyeglasses. With the reductions in clinical and contract health care programs, the burden automatically shifted to the tribal health department. With increased demand for services we were cut 10 percent.

Specific reductions included: elimination of health planner; reduced administrative cost and positions by 60 percent; reduced community health representative by 20 percent; and a 10-percent reduction in the alcoholism program.

It does not take a genius to see the impact on the ability to deliver health care at the Colorado River service unit. We have not seen the President's fiscal year 1983 budget and are not in a position to comment on any specifics. We can state unequivocally that any additional reductions will mean the total elimination of health services at Colorado River.

Before we present our recommendations, there are two specific requests that must be made. If our recommendations are implemented, they will be feasible. No. 1, replacement of the outpatient facility. A few years ago we ranked No. 1 on the priority list for facility replacement. We are not sure what happened, but that possibility suddenly vanished. This year we rank in the top five for replacement of our outpatient department. Ours is the only facility in the Southwest to rank in the top five. The Colorado River Indian Tribes, therefore, request a line item appropriation for replacement of our outpatient facility at Parker, Ariz.

Reinstatement of tribal health programs to the fiscal year 1981 levels. This recommendation is specifically addressing the fiscal year 1982 reductions in the community health representative program and tribal management. There seems to be some misunderstanding of the community health representative program. Otherwise, a 20.7-percent reduction should not have occurred. The CHR program at Colorado River is an integral and integrated component of the health delivery system. The majority of our work is geared toward inhome health care. This activity saves money and allows the limited medical staff to more effectively apply their skills. The amount of funds are not even a drop in the bucket of the Federal budget, but essential to health care on reservations.

As mentioned, we do have a number of specific recommendations that I hope that the committee takes and looks at seriously. Some may find the recommendations proposed by the Colorado River Indian Tribes radical. They are intended to be radical in the true mathematical sense, in that they address the basic or root issues confronting Indian people. For years we have been confronted with diminishing program resources, little or no local control over the resources, top heavy administration, and an ever-expanding service population.

These recommendations have been given considerable thought, discussion and analysis. They have been developed to be consistent with and support the critical concepts of the trust responsibility of the Federal Government, tribal sovereignty, self-determination. In addition to being compatible with these concepts, we believe they are realistic, economically feasible, consistent to the administration's policies, applicable to the Bureau of Indian Affairs and long overdue.

For the past 3 years the increased cost of operating the current Indian health systems has surpassed the appropriations. The two main factors have been inflation and increased personnel costs. Inflation is an issue we cannot address directly, but we can address the increased personnel costs. The annual costs of living increases, within grade increases, and other personnel increases have not been covered by the Pay Act appropriations. Since this is considered mandatory, the costs are covered by reducing expenditures in other categories, such as clinical services. Over the last 3 years this has eroded the base funding, excluding Federal personnel, to the point eliminating tribal health and medical programs. If this process is allowed to continue, Indian Health Service will be an organization of Federal employees administering a nonexistent Indian health program.

Corrective action is required. First of all, the Colorado River Indian Tribes are not opposed to Federal employees receiving cost-of-living increases. We are opposed if the increases are at the expense of programs for Indian people. Therefore, we propose legislation limiting increases in Federal personnel cost to the actual Pay Act appropriations. It is impossible to continue to justify salary increases at the expense of health services for the Indian people. There were no cost-of-living increases for Colorado River employees this year. There were layoffs. Is it too much to ask Indian Health Service, the Bureau of Indian Affairs, and other Federal agencies to do what many tribes and the private sector have had to do?

Second, for years the tribes have questioned the cost benefit of the managerial structure of Indian Health Service and the Bureau of Indian Affairs. The current structure is designed to keep decisionmaking out of the control of tribal governments by maintaining overstaffed area and central offices. The buildup of these structures has also drained resources from the point of service delivery. There have been attempts and discussions concerning the abolishment of area offices. Most of these have either met the resistance or are simply not possible under the Public Law 93-638 contracting process.

After analyzing why this has not happened, we recommend a different approach. Therefore, we recommend legislative language requiring a minimum of 25 percent of all nonservice unit, IHS, or agency, BIA, positions be transferred to the service unit or agency. In order for this to be of maximum benefit to the Indian programs, we would recommend that the positions be transferred as unclassified. The total cost per position could be easily calculated and the average cost, along with the position, be distributed equitably, based upon unmet need, to the service units or agencies. This will allow the service units and agencies, in consultation with the tribes, to use the positions to meet local priorities. This approach begins to decrease, not only the area offices, but central offices as well. It will increase services at no additional costs. It will also make it more feasible for tribes to utilize Public Law 93-638 in contracting to operate IHS and BIA programs.

A major issue is no local government control. The President and Congress have both indicated by the passage of the Reconciliation Act of 1981 the necessity and feasibility of transferring program funds with fewer restrictions to the States for local administration. This mechanism is commonly referred to as block grants. The President's state of the Union message outlines an additional transfer of funds and responsibilities to the States.

From our own experience and in reviewing testimony of other tribes, our requests for the delegation of authority to service units and agencies have fallen on deaf ears for years. We continue to call for the delegation of authority. However, we cannot support this delegation coming through a block grant for IHS and BIA programs. The block grant concept is not consistent with the trust responsibility invested with the Federal Government, especially with the BIA and IHS. Therefore, we recommend legislation requiring all funds currently being expended at the service unit, agency and tribal level be designated as hold harmless funds subject to service unit and agency control with tribal concurrence. The hold harmless funds designation should also cover the positions and funds redirected to service units and agencies under our previous recommendation. The result of this recommendation will produce the same effect of the block grants, but in addition it supports the government-to-government relationship between tribes and the Federal Government. It also carries with it the much needed delegation of authority and control by the local tribal governments.

If this recommendation is adopted, it would, for the first time, provide a stable funding base from which each tribe may begin to build its own future. We recommend legislation requiring a consolidation of all block grant funds under the Reconciliation Act that Indian tribes are or would be eligible for, be transferred to either the BIA or IHS for allocation to tribes. The implementation of this recommendation is now possible because allocation formulas have been developed. This also enhances and supports the government-to-government relationship and standardizes the process for local tribal control.

This has been probably the most difficult issue to resolve because it can become both a legal and moral question. Since 1977 when many tribes abolished a blood quantum as a criteria for membership and in 1981 when Indian Health Service ruled non-Indian male spouses were eligible for services, the demand for IHS services far exceeds the resources for those services. In recent surveys, we have found the number of persons at some service units, either non-Indian or less than ¼-degree Indian blood are receiving 40 percent of the total services. In Oklahoma alone they are projecting an additional 90,000 persons becoming eligible during 1982. Ninety-five percent of those are less than one-fourth degree Indian blood. This means the service population is growing geometrically. The impact is being felt in the Phoenix area as well. All of the new charts were reviewed for fiscal year 1981 at the Phoenix Indian Medical Center, and we found over 19 percent of all new charts to be for people who are either non-Indian or less than one-fourth degree Indian blood.

There is no way appropriations can keep pace with the increasing service population. We propose two recommendations to resolve this issue. We propose legislation establishing eligibility for services, for Indian Health Service and the Bureau of Indian Affairs, at one-fourth degree Indian blood or more.

In order to avoid confrontations with other tribes and the question of tribal sovereignty, we would add a second recommendation. We propose legislation that would allow service units and agencies, with tribal concurrence, to establish a sliding fee for services based on income for those less than one-fourth degree Indian blood, but eligible under the current regulation. The fees collected would remain at the facility providing the service.

In proposing these recommendations, we recognize they are not the ideal solution. We are not sure, given the economic condition there is an ideal solution. However, our proposals are sound and necessary if the Federal Government is to meet its trust responsibility.

We have talked to a number of Indian tribes and congressional staff people, and no one has been able to come up with a more viable plan. We request congressional action as soon as possible to implement these regulations. The Colorado River Indian Tribes stand ready to offer any assistance in working out the mechanics for the implementation of these changes.

Thank you, Senator, and if there are questions, my staff or myself can answer.

Senator **DeConcini**. Mr. Drennan, let me compliment you on a fine presentation. You have offered a number of suggestions, not just the problems. We are, of course, becoming more and more aware of the problems, but we need some suggestions, obviously. I am concerned here with a number of things you have mentioned.

The one that jumps out at me is in relationship to your outpatient facility: That a few years ago you were ranked No. 1, and this year you are ranked No. 5. I do not remember exactly how you put it, but between No. 1 and No. 5. Do you have any idea how that occurred? What explanation do you get?

Mr. **Drennan**. We do not.

Mr. **DeConcini**. Just, you are no longer No. 1.

Mr. **Drennan**. We are no longer No. 1, and I guess it is because of the fact we do not travel as often as we did at the beginning and asking for this back in Washington and keeping on top of it.

Senator **DeConcini**. I remember a couple of years ago when we got them to revise the list, and the merits were there for you to be No. 1 or No. 2, as I recall. Then all of a sudden it is No. 5. We will certainly attempt to delve into that, although it may be useless if there is no money there. But, when the money does come in, and sooner or later it will, be will certainly look into it.

I have no further questions. Do you have any questions?

Mr. **Mulkey**. Mr. Chairman, do you have any ideas on your recommendation for establishing a blood quantum as a requirement for services, either BIA or IHS, on how much money you are talking about in terms of bringing back to the tribes, or would you like to describe them?

Mr. **Drennan**. I would like to call on my health director on this.

Mr. **Crawford**. The only mechanism we have right now is to make any projects—would be to take medicare rates. IHS charges $44 for outpatients' visits and $200 a day for inpatients. At some service units the non-Indian or person of less than one-fourth degree Indian blood is receiving 40 percent of the total services. We asked in Oklahoma, and it was 42 percent, and there we are talking about 90,000 outpatients, an increase in 90,000 outpatients, visiting service units. The inpatients would be the same thing. The costs are very, very high. Arizona's IHS has been talking about coming up with a methodology to redistribute the entire base funding if it is to service non-Indian clients. If it would be for people—let's go with one-fourth degree Indian blood—it would take a very substantial cost.

If I may, on this point. We have a meeting of the Arizona Intertribal Council, and I noticed that last Thursday the Intertribal Council voted unanimously to support this recommendation.

Senator **DeConcini**. And the recommendation is?

Mr. Crawford. To establish eligibility for free service to those of one-fourth degree Indian blood or for those in the system to establish a sliding fee or service based on their income.

Senator DeConcini. If you did do that, you know, and you do not have more funds available, and it does not look like there are going to be more funds, are you not really exacerbating the problem. I realize the justification, but I wonder if you are doing a service to those you include when you cannot give adequate service.

Mr. Crawford. It would provide at least some revenue to give us an ability to generate some revenue to offset these costs, which we cannot expect from the Federal Government, so I think there are advantages, as opposed to disadvantages.

Mr. Mulkey. Someone mentioned that this proposal is an infringement on tribal sovereignty. What is your reaction to that, Mr. Chairman?

Mr. Drennan. I think when we talk in that line, it is a trust responsibility and the government-to-government relationship with the tribes and the Federal Government that takes place and enrollment in the tribe and our part of the tribal government. I think that relationship is there, and we feel if that is a cause of hard feelings, and so forth, that our members of the tribes decide.

Mr. Mulkey. So you do not view it as an infringement, necessarily, on the tribe's sovereignty. Would that be accurate?

Mr. Drennan. Yes.

Mr. Booth. May I elaborate a little further. This tribe has their own enrollment criteria for their membership. Nonrestrictive membership is based on one-quarter or more or even higher, so it is not really an infringement. Each tribe does have their own criteria of membership.

Mr. Mulkey. One last question. This recommendation; are you looking at this in terms of actual authorizing legislation or something that would be in an appropriation bill?

Mr. Crawford. We have discussed this before and the critical times we are facing right now. It may be more expedient for this year to include it in the appropriations bill, than take it to the authorizing committee. I just do not think we can afford to bring health care and service to any and everyone in this country with the limited health care funding, so I think our suggestion would be to include this in the appropriations bill itself.

Mr. Mulkey. Do you have any idea how many people would be denied care that presently receive services in your area or would have to pay something?

Mr. Drennan. I would give a figure of about 200 to 300.

Mr. Mulkey. Do they have means? I realize it is a sliding scale, but do they have the income to make some payment?

Mr. Drennan. I believe the majority, yes, has some.

Senator DeConcini. Thank you. Do you have questions?

Mr. Taylor. Related to the same thing John was into: first of all, you made the statement that since 1977 when many tribes abolished a blood quantum as a criteria for membership. I am not aware of the tribes doing that, particularly, starting in 1977.

Mr. Crawford. Mostly the five tribes in Oklahoma. They attempted, or adopted new criteria; the Cherokees, the Creeks, the Choctaws, Seminoles, and Chickasaws, and that is where we got that information about the 90,000. Of course, this is in Oklahoma alone. We have talked with the director of the Oklahoma area office. These are real people that are coming into the system.

Mr. **Taylor.** My recollection of what the Cherokees are doing, or are trying to do, is that they are trying to establish a two-track membership, largely because of the United States and what they did in laws dating from 1906 that caused them to lose control of the membership. They are attempting to establish their membership that dates from the 1906 descendancy rolls. It could be a political membership and the second membership would deal with blood. It may be through issuance of certificates of eligibility that they are identifying members.

Mr. **Taylor.** Surely, the figure of 90,000 is a shocking one because when I was on the policy commission we received testimony that there was a population of 140,000 and now we come up with 90,000 eligible.

Mr. **Crawford.** What were the dates of your meetings back there?

Mr. **Taylor.** 1976 and we filed a report in 1977. That is why I found the 1977 figure quite interesting. You also refer to some service units, and you mentioned that was Oklahoma. Is that more than one or just one?

Mr. **Crawford.** We are out of Parker, and we do not have the ability to talk to anyone, so we make phone calls and we receive information from the director at Tahlequah and also Claremore. They give us statistics, which we present to John at Parker.

Mr. **Taylor.** It is very interesting testimony. I think we ought to take a look at it. I've discussed this previously with John. The primary area where the quantum of blood creates any problem is in the five civilized tribes in Oklahoma, and I think that should be borne in mind as we consider this problem.

Mr. **Crawford.** Out here there is no residency requirement. They can live in California and in Arizona, and if the person has a 128th degree of Indian blood, they can get their cards, and they go off to the medical center, and they are required to provide them full service. This also has an impact on our health care. If someone comes in and needs to be hospitalized and they need to occupy a bed and then if someone comes in from Parker, it——

Mr. **Taylor.** It certainly is something that bears investigating.

Senator **DeConcini.** Our next witness is Leona Kakar, chairperson, and Delia Carlyle, health program director of the Ak-Chin Community Council.

Ms. **Carlyle.** My name is Delia Carlyle, and I represent Ms. Leona Kakar, chairman of the Ak-Chin Tribal Council.

I wish, with your permission, to ask Mr. Dana Norris, Sr., of the Gila River Indian Community to share our testimony and present the position of the Gila River Indian Community, which our tribe endorses.

Senator **DeConcini.** Would you come forward, Governor Norris?

Mr. **Norris.** My testimony comes later on the agenda, Senator.

Senator **DeConcini.** We can do it now. Do you want to do it now? Ms. Carlyle, are you finished?

Fine. We will hear Governor Norris then.

STATEMENT OF DANA NORRIS, GOVERNOR, GILA RIVER INDIAN COMMUNITY, ACCOMPANIED BY DELIA CARLYLE, AK-CHIN COMMUNITY COUNCIL; ROD LEWIS, GENERAL COUNSEL; AND HILTON HEDRICKS

Mr. NORRIS. Mr. Chairman, my name is Dana Norris, governor of the Gila River Indian Community.

Senator DeConcini and members of the Senate select committee: As governor of the Gila River Indian Community, which is consisted of both Pima and Maricopa Indians, I welcome this opportunity to address the issues of: No. 1, the establishment of a blood quantum as an eligibility requirement for Indian Health Service services; and, No. 2, the impact of the recent Federal funding reductions on health-care services available to my people. In respect to the establishment of a fixed blood quantum ratio as eligibility for services to be provided by the Federal Government under the mandate of the Snyder Act of 1955, it appears to me that there are two crucial issues which must be addressed.

The first issue is the sovereignty of the individual tribe and its right to establish eligibility requirements for membership in that tribe. Each tribe, I am certain, has at some time addressed this crucial issue as an internal matter concerning the maintenance of its land, water, and resource rights. This sovereignty of the individual tribes was originally secured by individual treaty and not by a collective action between the Federal Government and all tribes representing all Indians.

The second issue involves the question as to whether or not the intent of the Snyder Act, which was a reaffirmation of the special trust relationship between Indian tribes and the Federal Government, has been fully implemented. While there has been improvement in health services on Indian reservations since 1955, the health services available to the Indian tribes are not equal to that of surrounding communities outside the reservation. This fact is substantiated in a comparison of morbidity and mortality statistics as well as a comparison of available health care services.

Failure to implement the Snyder Act through subsequent legislation such as Public Law 93-638 and Public Law 96-437, which were both efforts to improve the health care by giving Indian tribes the right of self-determination, Public Law 93-638, and specific funds to raise the level of health care services, Public Law 96-437, place the Indian tribes in particular jeopardy at the present. The present reduction in funding for IHS fails to recognize that Indian tribes have not achieved minimal levels of adequate health care through the earlier efforts and are, therefore, already seriously disadvantaged before the proposed funding reductions.

If the blood quantum ratio is proposed as a possible budget reduction through reduction of persons eligible for service, we should also consider those actions not initiated by the tribes which have added to the service population. The action I refer to is the "on or near" populations, the equal rights spouse decision, and the inclusion of nonreservation Indians as services-eligible. The effect of all of these events, including the lack of a clearly defined blood quantum ratio, has been to add a very large but undetermined number of persons to be served.

The IHS has been asked to serve this steadily increasing service population, not with the same budget, but with reduced budgets. In some cases this has almost amounted to a double reduction, for instance, increasing service to more persons with reduced funding.

I view the impact of currently proposed funding reductions on the health care available to my tribal members from two perspectives: No. 1, its impact on the beginning self-determination process begun under Public Law 93-638 in 1976; and, No. 2 its impact on the tribal access to Federal funding under the guarantee of the special trust relationship between tribes and the Federal Government.

In respect to the self-determination process my own tribe has developed a tribal health department, which supplements the services of IHS through Sacaton IHS hospital and the Phoenix Indian Medical Center. At this point in time the health care system available to our residents is a coordinated effort of the tribal health services and the IHS service. Failure to recognize that the tribal service contracts are at this point a vital part of the health service may constitute a serious error. In the first instance, IHS programs reduced through transfer of service will not be able to restore service if the tribal contracts are not maintained. In the second place, failure to continue the Public Law 93-638 process, which was in itself a powerful restatement by Federal Government regarding its position in respect to human rights, may risk a complete undoing of 6 years of work by tribal members and governmental personnel.

My final point regarding the impact of the proposed funding reductions deals with the need for direct tribal access to Federal funding on an equal status with the States.

In the proposed Federal budget, the tribes are not permitted direct access to Federal funding except under special circumstances, which eliminate the majority of tribes from eligibility. Access to Federal funding by the tribes under the proposed State block grant procedure provides that the tribes may have access through the State to these funds.

However, there are two problems with this proposal. First, the State is not required to honor the special Federal relationship with the tribes. Hence, the States have no obligation to the tribes and there is no mutual relationship. The States and tribes are at a loss as to how to deal with one another. The State's only guideline for such a situation is to attempt to treat the Indian reservation as a local government. Any attempt on the part of the State of Arizona to treat an Indian reservation as a local government will only raise problems.

Second, the States, having sustained a considerable loss in total dollar volume through the block grant process, are quite simply not able to accept the additional service population of the Indian reservations.

Senator DeConcini, I have spoken honestly and candidly concerning my feelings regarding the subject under discussion. I would not have spoken so directly had I not felt that you understand the problems of the Indian population. I also would be most remiss if I did not thank you for your unflagging effort to assist Gila River through the construction of a desperately needed replacement hospital.

Thank you very much.

Senator **DeConcini**. Thank you, Governor Norris, for your candid, well-presented statement.

Regarding that last matter, that desperately-needed replacement hospital, is that moving along at the proper rate or have you stumbled into problems with the OMB or anyone?

Mr. **Norris**. Senator, I would like to ask the general counsel on my left to speak to that.

Mr. **Lewis**. Senator, we had difficulty with OMB. The funds still have not been released, and we are having difficulty getting IHS assurances that the hospital can be funded and funds for the hospital can be released for initial design and construction.

Senator **DeConcini**. Even though the funds have been appropriated for that?

Mr. **Lewis**. Even though the funds have been appropriated, it is my understanding OMB is undergoing some sort of review process, and those funds have not yet been released.

Senator **DeConcini**. If you will work with John, we will do what we can in Washington to get an answer and see that they comply with the mandate of Congress and proceed with this after so many years.

Mr. Norris, you make a statement here that any attempt on the part of the State of Arizona to treat an Indian reservation as a local government will only raise problems. Are you making reference to the block grant proposed or are you discussing the block grants programs through the States? Is that what you are making reference to?

Mr. **Norris**. Yes, sir.

Senator **DeConcini**. Thank you very much. I have no other questions.

John.

Mr. **Mulkey**. Just for the record. Governor, do you support the Colorado River Tribe's proposal on the establishment of a blood quantum?

Mr. **Lewis**. The tribal council has not officially acted as far as the blood quantum issue is concerned. I think we strongly agree this ought to be looked at in some degree, and, certainly, any way that funds can be cut down and more actually delivered out to the reservations is something we strongly support.

Senator **DeConcini**. Comment?

Mr. **Hedricks**. Senator, if I may, we do have and will present at a later date quite a long paper prepared on the subject for the CHR and OMB hearing.

I would like to restate again what Governor Norris has said regarding the statement regarding the fee-shared responsibility of this present reservation between IHS and tribal programs. Failure on the part, as you so well pointed out earlier, failure on the part of OMB, or whatever, to realize that CHS programs have been utilized with CHR moneys, have been utilized as the need of developing tribal programs, which now have responsibilities, but which the IHS cannot fulfill. In effect, we have a bird here with two wings, and it needs both to fly.

Senator **DeConcini**. Thank you.

Mr. **Taylor.** I have one question. This again goes to the quarter blood and the concern of the Arizona tribes with respect to the standard, and I think the statement of the previous witnesses very correctly raises very difficult legal issues and very difficult moral issues. I have the feeling that the concern is arising from the apparent activity in a few service areas of Oklahoma that indicates there may be a jump of 90,000 service-eligibles. If upon our examination we find that this jump is not going to actually occur, that this is apparently just the constitution of these tribes, that is the extended membership, but, in fact, the service population will not be taking that 90,000 jump, would this affect your thinking on whether you want to support the quarter-blood standard?

Mr. **Lewis.** If it turns out that the quarter blood requirement increases services, I think that is something that is really going to require a good look. However, I am not sure what our position will be. The tribe itself has the quarter blood to be a member of the tribe, and the BIA, we understand has a quarter-blood requirement. We think some sort of minimal blood requirement ought to be in effect for BIA and IHS. In addition to that, as Governor Norris pointed out, the non-Indian spouses who are provided service, I think, is another problem area. Service provided on or near the reservation, that is another field in which our services could certainly be reduced, perhaps.

Mr. **Taylor.** I think that occurrence came about because of the civil rights movement or the ERA, because for years non-Indian dependents, female spouses, were entitled to health service, and the equal rights question came up, at which point the eligibility, I believe, was extended to the male spouses.

Senator **DeConcini.** We are going to have to move along. Anything else?

Mr. **Hedricks.** Just one final statement, I think we should be very careful and ever mindful of transferring populations back and forth. Actually they could end up under medicare or under an outsider or the State. I know Governor Babbitt has been extremely supportive to develop health systems because he knows that he could not afford to take care of 9,500 more people, and the tribe does not want him to do this. We ask the chance to operate alone.

Senator **DeConcini.** We will take a 5-minute break at this time.

[Recess.]

Senator **DeConcini.** The Senate Select Committee on Indian Affairs will come to order.

At this time we will go on to the Camp Verde Yavapai-Apache Indian community, Mr. David Kwail, vice chairman. Are they here?

Is Mr. Kwail here? Are any representatives here? Anyone for the Camp Verde Yavapai-Apache Indian community here?

If not, we will go to the Cocopah Tribal Council.

Please come forward.

A **Voice From the Audience.** Good morning. It was my understanding that Chairman Barley would be here, but he has not arrived.

Senator **DeConcini.** That is all right. Do you want to proceed? Do you have his statement or——

Ms. **Ramsey-Keane.** No; this is the only statement that was prepared.

Senator **DeConcini.** You are?

STATEMENT OF ROXANNE RAMSEY-KEANE, DIRECTOR, TRIBAL HEALTH MAINTENANCE PROGRAM, COCOPAH TRIBE

Ms. **Ramsey-Keane.** I am Roxanne Ramsey-Keane, director, tribal health maintenance program of the Cocopah Tribe.

Senator DeConcini and committee members: The sovereign nation of the Cocopah is very distressed about the Indian health budget cuts for fiscal year 1982. We strongly protest these budget cuts on the grounds that they are extremely prejudicial toward the native American population residing in the United States and Alaska.

The Cocopah Tribe live on two reservations and land held in trust for them by the U.S. Government, totaling 1,765 acres, with tribal membership numbering 586 and with 422 residing on reservation land. There is an unemployment rate of 38 percent. This rate should be compared with 14 percent in Yuma County and 14.9 percent in the city of Yuma. This creates a severe problem for the Cocopah people. Of the 77 households on reservation land, 100 percent are below poverty level. Those that are employed are not covered sufficiently by their employers to have adequate medical and surgical insurance.

The Indian Health Service hospital at Fort Yuma is the only facility that will accept these people in our area. Phoenix Indian Medical Center is where many of the Cocopah would prefer to receive medical attention, but this center is 200 miles from the Cocopah Reservation thus presenting a 400-mile round trip for any who seek clinical assistance there. Many of our people do not have transportation and cannot afford to take a bus or other conveyance. Therefore, they lack proper medical attention.

The Cocopah Tribe has 112 diabetics, four that are under age 18, 2 diabetic amputees, 2 diabetics with complete renal failure receiving dialysis, and 2 borderline renal failure diabetics. At the present time we have 9 active cases of tuberculosis, 3 of which are school-age children now receiving treatment. There are also three reactive cases of tuberculosis receiving treatment. There are 86 patients on the hypertension registry. In the past 1½ years the Cocopah Tribe has had three tribal members undergo open-heart surgery.

Our alcohol and drug abuse program, ADAP, has served 190 clients in the past year, forty of which were under 18 years of age and 15 were over 55. Alcohol abuse contributes to 5 of the 10 leading causes of death among Indian people, including the following: accidents, cirrhosis, suicide, homicide, and alcohol abuse itself as a primary diagnosis. Among American Indians 95 percent are directly impacted by alcohol abuse within their families or communities while 80 percent of all suicides involve alcohol. In the past year there have been 3 documented cases of unsuccessful suicide attempts with at least 10 cases undocumented.

Indian Health Service is an essential part of the Indian's welfare, and the impact of present and future budget cuts will be felt by our native Americans in a most detrimental way.

Senator **DeConcini.** You are a nurse there?

Ms. **Ramsey-Keane.** Yes; I am.

Senator **DeConcini.** On the reservation?

Ms. **Ramsey-Keane.** Yes.

Senator DECONCINI. Do you treat many of these patients?

Ms. RAMSEY-KEANE. Yes; I give direct care in the home to the chronically ill, the elderly, and the sick patients.

Senator DECONCINI. Is there a doctor on the reservation?

Ms. RAMSEY-KEANE. There is not. And this is the first time the Cocopah Tribe has ever had a tribal nurse.

Senator DECONCINI. When did you commence?

Ms. RAMSEY-KEANE. December of 1981.

Senator DECONCINI. So, they had to go to Fort Yuma for any health care prior to that time?

Ms. RAMSEY-KEANE. That is correct.

Senator DECONCINI. How far is that?

Ms. RAMSEY-KEANE. Fort Yuma is 20 miles one way, and a 40-mile round trip.

Senator DECONCINI What services are there?

Mr. RAMSEY-KEANE. Diabetic clinic. They have hypertension screening. I believe 16 beds for inpatient care. They have prenatal care for the young women, and they do have an eye clinic, I believe, twice a month. I don't believe they are adequately staffed for trauma.

Senator DECONCINI. Is that where the alcohol program is run?

Ms. RAMSEY-KEANE. Well, the Cocopah Tribe has an alcohol-drug abuse problem related to the reservation. In Somerton there is another program similar to that out of Fort Yuma.

Senator DECONCINI. Thank you for your testimony.

Does any staff member care to ask any questions?

If the tribal chairman does come, please advise him that we will be more than happy to include any statement he has, if he will present it to Mr. Mulkey.

Thank you very much.

Ms. RAMSEY-KEANE. Thank you.

Senator DECONCINI. We will now hear from Mr. Ronnie Lupe, chairman of the White Mountain Apache Tribe.

Welcome, Mr. Lupe, would you introduce your colleague there for the record.

STATEMENT OF RONNIE LUPE, CHAIRMAN, WHITE MOUNTAIN APACHE TRIBE, ACCOMPANIED BY CHARLIE O'HARA, HEALTH DIRECTOR

Mr. LUPE. Mr. Chairman, members of the committee, I am Ronnie Lupe, chairman of the White Mountain Apache Tribe of East Central Arizona. On my left is Charlie O'Hara, health director on our reservation.

I am here, gentleman, to bring to your attention my tribe's priority health care needs and related health issues which affect both our health care delivery system and the health status of the 9,000 White Mountain Apaches that I represent.

In order to be brief, I will eliminate some of the written testimony and do the highlights of the major issues and concerns in my oral testimony. The written testimony is in your hands now.

During the past few years on our reservation, along with other people, I have witnessed progress and development of a comprehensive health care system. This health system has included a new, well-staffed IHS hospital, a new clinic in the remote community of Cibecue, and an effective tribal health authority coordinating community and hospital services, which complements the services of the Indian Health Service. Most recently, we have had reason for great pride in the appointment of our own tribal member and former health authority director, Ms. Carla Baha-Alchesay, who is present in the audience, as our service unit director, one of the few women in Indian Health Service to occupy such a position.

But, unfortunately, my optimism is eroding. At this time the model health care system that the tribe and Indian Health Service has worked hard to develop is being seriously threatened and slowly dismantled as a result of recent budget cuts, and it is all the more painful to witness this since we have come so close to realizing our long-standing dreams. The cutbacks on our funding for IHS regarding our White Mountain Service Unit Hospital on your reservation is of great concern, not only to myself but also to the people of the White Mountain Apache Tribe.

Please understand that the tribe is very grateful for the congressional appropriations in the recent past. It has provided us with a new IHS hospital and clinic with adequate staffing levels, but now also understand our frustration at the most recent congressional IHS budgetary process that both jeopardizes our past accomplishments and creates administrative and service delivery chaos for those that must implement those budgetary decisions.

Let me emphasize four health care problems and concerns that presently confront us.

No. 1, alcoholism continues to be the most serious health problem among the White Mountain Apaches and Indian people in general. It is the No. 1 killer of our people. Although Indian Health Service has voiced their concern about the magnitude of the problem for over 10 years, they have done little else to address the problem. I strongly urge that Indian Health Service take a leadership role in the treatment of alcoholism by assuming the responsibility of providing initial inpatient treatment of the alcoholic.

No. 2, the fiscal year 1982 IHS budget process has been a catastrophe in terms of the impact of specific budget cuts, and the dismay apparent within the Indian Health Service as a result of continuing resolutions, deferrals, and other actions designed to reduce the health care dollars available to Indian people. As of this date, 5 months into the fiscal year, neither the Phoenix area office, the Whiteriver service unit nor the tribal health authority programs have a firm budget figure, but, as requested in the past, when the area IHS budget is known, I trust that information will be shared with the tribe.

Presently, health program decisions are being made based on unknown quantities and conjecture. In short, the fiscal year 1982 budget and its method of implementation has created a mess, and it is hard to believe that that mess is not seriously affecting the quality of health care for Indian people.

No. 3, in the face of reduced budgets IHS has had to absorb the costs of commissioned officers' transfers from PHS hospitals. I understand in the Phoenix area alone these costs amounted to approximately $1.2 million. I know in the Whiteriver service unit the costs of these commissioned officers' transfers exceeded $84,000, and not a dollar of that money resulted in additional health care for White Mountain Apaches. I trust you can understand my consternation over this type of personnel finagling and hidden costs that result in costs which are ultimately borne by Indian people.

No. 4, the White Mountain Apache Tribe presently encounters severe health problems as a result of the high incidence of diarrhea on the reservation. These problems are related to the reservation's inadequate sanitation system. Specifically, we lack proper sewage and solid waste disposal systems. The resulting diarrheal problems are the leading cause of outpatient visits and hospitalizations during the summer months.

The Whiteriver regional wastewater management system is presently under construction. The tribe is presently on the EPA funding list for the remaining phase of the project, but with the current EPA cutbacks we fear that this project is in jeopardy.

The Cibecue sewer project was originally funded by IHS in 1977 at a projected cost of $600,000. Today we are told additional funds needed to complete the entire project are estimated to be $600,000.

A proposal to construct a sanitary landfill has been submitted by the tribe to HUD under the community development block grant program. I respectfully ask your support for those three projects.

It seems unfair to me that the present administration is proposing additional funding for foreign aid while cutting funds for Indian citizens facing similar sanitation problems.

Quality health care for the elderly has been a longstanding concern of the tribe, but the improvement of services for these Indian people who have often suffered the most will be delayed and in some cases reduced due to budgetary cutbacks. Cutbacks have resulted in reduced home health and home visit services to the elderly population that needs these services.

The HUD-Menninger project, a demonstration project, is indefinitely stalled due to lack of an operational funding commitment of approximately $250,000 from the Department of Health and Human Services.

The fiscal year 1982 IHS budget reductions present a serious setback to the tribe's continuing progress under the Indian Self-Determination Act. We have developed an effective tribal health management system and excellent programs, such as health education and emergency medical services. There is a cooperative working relationship between the tribal health authority and the Whiteriver service unit that should be a model for Indian Health Service, but the fiscal year 1982 budget reductions were targeted most heavily at those Indian Health Service sources of funding that support tribal programs.

Contracting under Public Law 93-638 continues to be excessively restrictive and administratively burdensome. The Indian Health Service should be encouraged to explore the potential of cooperative agreements as a funding mechanism that is more compatible with the spirit and intent of the Indian Self-Determination Act.

Recent proposed legislation by the Secretary of Health and Human Services appears to be a direct attack on our tribal sovereignty and the Federal Government's trust responsibilities. Section 711 of Public

Law 94-437 would amend that law to permit concurrent State jurisdiction over Indian Health Service facilities. Section 404 of Public Law 94-437 would permit nonbeneficiaries to utilize remote IHS facilities, but on our reservation those facilities have long-waiting periods and full occupancy rates. How do you expect us to handle additional patients in the face of budget reductions and reduced staffing? The implementation of recent regulations that expanded IHS beneficiaries to include non-Indian husbands have cost the service unit approximately $50,000, which has to be absorbed along with budget reductions. This is an untenable position. IHS and the Congress cannot continue to increase the total number of beneficiaries with no increased funding. The result of such actions is an erosion in the quality and the quantity of health care services for Indian people and represents an abrogation of treaty and trust responsibilities.

In 1976 in testimony presented before the Indian Policy Review Commission's Task Force on Indian Health, I testified that we had six White Mountain Apache students pursuing some type of health career. Today I take pride in reporting we presently have 55 students pursuing health careers at 16 colleges and universities. This is the direct result of the efforts of our health careers program, but funding for this program under Public Law 94-437 has been eliminated, and the program is being phased out. The students are being left high and dry to face the prospect of returning to our reservation, which is facing staff reductions in both IHS and tribal health programs. I am embarrassed to tell them they followed empty promises, but it seems that we have all had to swallow our share of empty promises in recent months.

Gentlemen, I am sorry to close my testimony on such a pessimistic note. We are grateful to the Congress and the Indian Health Service for their role in our accomplishments over the past few years, but I see little cause for optimism under the present administration's proposed budget reductions. What I see is a dream rapidly fading.

Senator DECONCINI. Thank you very much for a fine statement, and I, too, am not optimistic at this point, by any means, regarding your sanitation system and district there. What sources now are available for the new hospital? Is there a separate sanitation system for the hospital that has been finished?

Mr. LUPE. What we have, Senator, is oxidation ponds, and they are put into every community to provide for oxidation. The oxidation ponds drain into our main river where our kids swim and some of our people drink the water and create a hazard to health. That is where our present system is in the Whiteriver community. What we want to do is improve upon that and have a cycle plant established to take care of and eliminate the oxidation ponds.

Senator DECONCINI. That is under construction?

Mr. LUPE. And now we are concerned with budget cutbacks.

Senator DECONCINI. You are concerned that budget cuts during the process of construction would reduce the quantity or would it just stop the whole thing?

Mr. LUPE. I think it would completely stop everything.

Senator DECONCINI. And be a big waste of money already invested if we do not go through with it.

Mr. Lupe. It is pretty hard to get on the EPA and get State funding sources and so forth. We have been on top of the list for a long time, and we have high hopes of getting funded from the State. It is a huge sum of money. We have just started, and now with no funding available, I am afraid there is a definite setback with no alternative.

Senator DeConcini. What about the housing that is next for the hospital staff?

Mr. Lupe. Congress appropriated some funds, $5 million for us, and we built about 60 units.

Senator DeConcini. Are those under construction or completed?

Mr. Lupe. They were built a year ago.

Senator DeConcini. Are they finished?

Mr. Lupe. Yes, completed.

Senator DeConcini. I just want to be brought up to date. Thank you.

Mr. Lupe. See, additional construction for housing created a strain on our oxidation ponds.

Senator DeConcini. And that $5 million for additional housing did not include any funds for sewage treatment?

Mr. Lupe. No; well, it's just taken over. Everywhere you look our oxidation ponds are overflowing, and that is a health hazard, and the diarrhea is a tremendous problem of our younger generation.

Senator DeConcini. Well, Chairman Lupe, I agree with your statement that this country has its priorities a little confused with foreign aid. We are witnessing tremendous cuts in the budget on programs, not only for Native Americans, but for others also, and I certainly wish we could get our priorities in line. If we do have to cut needy projects, I sure feel we need to take care of those at home first. We have not done that, at least in the area of foreign aid, and there will be many of us, Democrats and Republicans, who will continuously request for increased foreign aid, even though there are human needs here, because if you come down to trading off human needs, if you have to do it, certainly I agree with you, Mr. Chairman, we have these undeveloped resources right here and people in the United States, and many of them Native Americans. We ought not to ignore and spend the taxpayer's dollars overseas.

Do any one of you have any questions?

Mr. Mulkey. Just for the record, Mr. Lupe, what is your position regarding the Colorado River Tribes' proposal on a blood quantum requirement?

Mr. Lupe. I congratulate my friend, the chairman of the Colorado River Tribes, on making a fine presentation, and I am sure the other chairmen feel the same way, and I completely endorse his concerns.

Mr. Mulkey. Do you have any idea what impact it would have if it were implemented? In Whiteriver would there be people currently receiving services that would no longer be eligible and to have to pay something?

Mr. Lupe. Right now with the budget cutbacks for me in my hospital to take care of all the others, to follow the suggestion that the same people utilize my hospital at Whiteriver where facilities are reduced anyway, I cannot take care of that patient. It would be a health hazard to them. Their safety would be in jeopardy. Our hospital is full and then along come people who have married into my tribe who are not members, and Congress is trying to qualifv them to take part in the IHS. There is no money available for them, and if 90,000 people are coming aboard with no extra funds being appropriated for them to take advantage of the IHS, it creates a hell of a chore on our reservations. As far as the medical need and care for our people, they would be a disadvantage.

Senator DECONCINI. Thank you, Mr. Chairman.

Your complete statement will be included in the record at this point.

[The statement follows. Testimony resumes on p. 374.]

Testimony

Presented by Ronnie Lupe, Chairman

White Mountain Apache Tribe

Indian Health Service Oversight Hearings

February 15, 1982

Mr. Chairman, Members of the Committee, I am Ronnie Lupe, Chairman of the White Mountain Apache Tribe of East-Central Arizona.

I am here today to bring to your attention my Tribe's priority health care needs and related health issues which affect both our health care delivery system and the health status of the 9,000 White Mountain Apaches that I represent.

During the past few years on our Reservation, I have witnessed exciting progress in the development of a comprehensive health care system. This health system has included a new, well staffed, IHS Hospital; a new clinic in the remote community of Cibecue; and a Tribal Health Authority exemplifying the spirit of the Indian Self Determination Act. The Tribal Health Authority has developed an impressive array of community and hospital based services that complement those available through the Indian Health Service. Most recently, we have had reason for great pride in the appointment of our own Tribal member and former Health Authority Director, Ms. Carla Baha-Alchesay as our Service Unit Director, one of the few women in Indian Health Service to occupy such a position.

But, unfortunately, my optimism is eroding. In the face of budget cutbacks and staff reductions, that model health care system that the Tribe and Indian Health Service has worked hard to develop is being seriously threatened and slowly dismantled. And, it is all the more painful for me to witness this since we have come so close to realizing our long standing dreams. We envisioned a community health system adequately staffed by qualified, professional health providers effectively combining the best of Western medicine with a culturally defined, hoslistic approach to health maintenance and health promotion.

Please understand that the Tribe is very grateful for the Congressional appropriations in the recent past. Appropriations that have provided us with a new IHS Hospital and Clinic with staffing levels that were commensurate with the health needs documented in the Tribal Specific Health Plan.

But, now, also understand our frustration at the most recent Congressional IHS budgetary process that both jeopardizes our past accomplishments and creates administrative and service delivery chaos for those that must implement those budgetary decisions.

Let me detail for you the problems and concerns that presently face us:

1. Alcoholism continues to be the most serious health problem impacting the White Mountain Apaches and Indian people in general. It is the number one killer of our people. Although, Indian Health Service has voiced their concern about the magnitude of the problem for over ten years, they have initiated little in the way of acceptance of responsibility for the initial treatment of the Indian alcoholic or in the development of effective treatment modalities. Indian Health Service views alcoholism as a tribal problem rather than a medical problem. The scant resources available to deal with the problem are often fragmented among competing entities rather than combined in a unified or cooperative approach. It seems ironic that the Congress and Indian Health Service are willing to spend millions in the treatment of the medical complications of alcoholism but are niggardly when it comes to dealing with the problem itself.

Based on the recommendations and insights of our Tribal Alcoholism Director which are contained in greater detail in a letter attached to this testimony, I strongly urge that Indian Health Service take a leadership role in the treatment of alcoholism by assumming the responsibility of providing the initial in-patient treatment of the alcoholic, using the existing resources of their staff and facilities. This action would permit the focusing of the limited alcoholism resources on the residential treatment and aftercare of the alcoholic and would earn Indian Health Service a partnership role in the development of an effective treatment plan. This change in approach must come soon before the bulk of the IHS budget is squandered on the treatment of end stage liver disease and other medical consequences of the problem of Alcoholism. We need more money for Alcoholism programs but we also need committment and leadership on the part of the Indian Health Service.

2. The Fiscal Year 1982 IHS Budget process has been a catastrophe in terms of the impact of the specific budget cuts, the delayed approval of the final appropriations, and the dismay apparent within the Indian Health Service. This dismay is the result of continuing resolutions, deferrals, and other actions designed to reduce the health care dollars available to Indian People. As of this date, five months into the fiscal year, neither the Phoenix Area Office, the Whiteriver Service Unit nor the Tribal Health Authority programs have a firm budget figure. But, as requested in the past, when the Area IHS budget is known, I trust that

the information will be shared with the Tribe.

Presently, health program decisions are being made based on unknown quantities and conjecture. The Whiteriver Service Unit, for example, had a $250,000.00 deficit at the end of the first quarter of the fiscal year and had few of the necessary administrative tools to deal with it. The Service Unit has had to absorb the 14% pay increases of Commissioned Corps personnel and the 4% raises for Civil Service personnel with no additional funding. Positions are being lapsed and services are being reduced with no clear parameters in sight. The adequate staffing that was assured for the Whiteriver hospital and Cibecue Clinic by Congress is dwindling daily. Service Units and direct care services seem to be bearing a disproportionate share of budget cuts without comparable reductions at the Headquarters and Area levels. Further reductions in nursing staff at our Service Unit will compromise patient care and result in the closure of hospital beds. Physician and Dental services at Cibecue are, or soon will be, severaly reduced. The morale of IHS Service Unit and Area Office personnel seems to be at an alltime low as a result of the uncertainties and restrictions created by the budget activities at the National level. Qualified personnel are departing Indian Health Service as a result of the recent vicissitudes and unpredictability of the political and budgetary process. Probelms of physician recruitment will intensify for Indian Health Service with the elimination of PHS Scholarship funding. In short, the FY82' budget and it's methcd of implimentation has created a mess and it's hard to believe that that mess is not seriously effecting the quality of health care for Indian people.

3. Someone in the Department of Health and Human Services must have forseen the impact that the closure of Public Health Service hospitals and the resultant transfer of Commissioned Officers would have on the Indian Health Service. Yet, in the face of a reduced budget, Indian Health Service has had to absorb the costs of these transfers which include the overlapping salaries of the new transfer and the outgoing lower ranking personnel, transportation of household goods, mileage, per diem, storage and dislocation costs. I understand in the Phoenix Area alone these costs amounted to approximately 1.2 million dollars. I know in the Whiteriver Service Unit the costs of these Commissioned Officers transfers exceeded $84,000.00, and not a dollar of that money resulted in additional health care for White Mountain Apaches. However, it did result in the loss of a Dentist position at the Cibecue Clinic when the transferred Dental Officer, an 0-4, after one day, decided that he could not tolerate the remote location. The young, dedicated dentist that had enjoyed the position and the community had already been transfered to another Area.

I trust that you can understand my consternation over this type of personnel finagaling and hidden costs that results in additional deficits for Indian Health Service. Costs which are ultimately borne by Indian people.

4. The White Mountain Apache Tribe presently encounters severe health problems as a result of the high incidence of diarrhea on the Reservation. These problems are related to the Reservation's inadequate sanitation system. Specifically, we lack proper sewage and solid waste disposal systems. The resulting diarrheal problems are the leading cause of out-patient visits and hospitalizations during the summer months. Yet, the FY82' IHS Budget has severly reduced the funds available for sanitation and preventive health, in general. The reduced federal funds of various agencies now threaten several projects on the Reservation which, when completed, will alleviate many of the health problems associated with inadequate sanitation systems.

The Whiteriver Regional Wastewater Management System is presently under construction. The project was divided into two construction phases at an estimated cost of $5,974,225.00 in 1978 dollars. Phase one at a cost of 1.3 million is underway. The Tribe is presently on the EPA funding list for the remaining phase of the project. EPA would fund 75% of the project cost. However, with the current EPA cutbacks we fear that this project is in jeopardy and request your support for the remaining funding and completion of the project.

The Cibecue Sewer Project was originally funded by IHS in 1977 at a projected cost of $600,000.00. However, due to engineering and related delays, construction did not begin until 1981. As a result of inflationary factors, the original allocations will permit the completion of only half of the original project. Because of the configuration of the project, the section that will be unfinished will leave a high density area of the community without adequate sewage disposal. The additional funds needed to complete the entire project are estimated to be $600,000.00.

A proposal to construct a sanitary landfill on the Reservation has been submitted by the Tribe to HUD under the Community Development Block Grant program. The total funds requested from HUD are $367,000.00. IHS has committed $50,000.00. BIA had originally indicated that $267,000.00 would be available for the development of a solid waste collection system but has since withdrawn that committment. This is an important project and needs your support.

I have included as an attachment to the written testimony a letter from Dr. M. Santosham, a Research Physician from John Hopkins University that has been studying the diarrhea problem on our Reservation. In his letter, he compares the situation on our Reservation to problems encountered in developing countries and urges your support for funding for sewage and solid waste disposal.

It seems strange to me that the present Administration is proposing additional funding for foreign aid while cutting funds for Indian citizens facing similar sanitation problems.

5. Quality health care for the Elderly has been a long standing concern of the Tribe. But the improvement of services for these Indian people who have often suffered the most are being delayed and in some cases reduced due to budgetary cutbacks, lack of start-up funding and the lack of committments on the part of federal funding agencies.

Severe reductions in the Community Health Representative budget is resulting in reduced home health and home visit services to the Elderly population that need these services. The CHR Program has been responsible for the provision of many of the support health services that allow the Elderly to remain in their homes and out of the hospital or nursing home. CHR services have significantly reduced the debilitation of the Elderly. But, again this year, we must convince the Congressional appropriations committees that the program is worthwhile for again the Administration has proposed to eliminate the program in the Fiscal Year 1983 budget.

The Tribe's dream of a Tribal Nursing Home that would eliminate the necessity of sending Elders off the Reservation to nursing homes in a strange environment when they are their sickest must be postponed. The lack of start-up funds and other funding committments will force the development of a Tribal nursing home to be relegated to the status of a long range plan.

Finally, the HUD-Menninger Project, a demonstration project, which has been in development since 1978 is definitely stalled due to lack of an operational funding committment of approximately $250,000.00 from the Department of Health and Human Services. The project, designed to provide custodial care primarily for the Elderly, has been a high priority of the Tribe and countless Tribal staff hours and other resources have been committed to the realization of this project. HUD has committed to fund the construction portion of the project as well as the building maintenance cost. IHS has committed to fund the costs of sewer and water installation. They had also attempted to take the lead in securing the operational funding, but to avail. The HUD-Menninger Project seems hopelessly stalled and has become an excessively long exercise in bureacratic frustration. Without a committment of operational funding by HHS, HUD cannot construct the units and the Tribal Elders continue to be deprived of the care they desperately need.

6. The FY82' IHS budget reductions present a serious setback to the Tribe's continuing progress under the Indian Self-Determination Act. In the past six years, the White Mountain Tribe has made significant strides in assuming greater responsibility for our own health care. We have

developed an effective management system and excellent programs such as Health Education and Emergency Medical Services. There is a cooperative working relationship between the Tribal Health Authority and the Whiteriver Service Unit that should be a model for Indian Health Service. But the FY82' budget reductions were targeted most heavily at those IHS sources of funding that support Tribal programs under Public Law 93-638, the Indian Self-Determination Act. Specifically, the Community Health Representative budget was reduced by 20.7% and the Tribal Management budget was reduced by 13%. This appears to be a clear reversal of the committments made by previous Congresses to Public Law 93-638. The Community Health Representative budget alone provides 75% of the funding for our Tribal Health Authority. Not only does this budget provide the funding for Community Health Representatives but also Emergency Medical Technicians and Health Authority management staff. If the Administration is successful in eliminating funding for the Community Health Representative program, they will be successful in virtually eliminating most of the progress in health areas made in recent years under the Indian Self-Determination Act.

7. Contracting with Indian Health Service under Public Law 93-638 continues to be excessively restrictive and administratively burdensome. I could document the excessive hours of our staff time spent on appeals and requests for entitlements that are clearly spelled out in the law. Often we don't even receive the courtesy of a reply. At a minimum, IHS officials should be required to make a written response to our written inquiries within a reasonable time period. But much of the problem is inherent in the nature of the funding mechanism, the cost reimbursement contract, which is better suited for procuring hardware than for defining a partnership relationship for the delivery of human services to Indian people. In the hands of an insensitive Contracting Officer, the regulations governing the administration of cost reimbursement contracts can and do become an oppressive club with most of the leverage in the hands of the Contracting Officer. Indian Health Service should be encouraged to explore the potential of cooperative agreements as a funding mechanism that is more compatible with the spirit and intent of the Indian Self Determination Act.

8. Recent proposed legislation by the Secretary of Health and Human Services appears to be a direct attack on our Tribal sovereignty and the Federal Government's trust responsibilities. Section 711 of Public Law 94-437 would ammend that law to permit concurrent State jurisdiction over Indian Health Service facilities. In effect, the amendment would permit the States to dictate standards to the Tribes on their own Reservations through the Indian Health Service. This is totally unacceptable.

Section 404 of Public Law 94-437 would permit nonbeneficiaries to utilize remote IHS facilities. We have remote IHS facilities on our Reservation and we already suffer long waiting periods and full occupancy rates. How do you expect us to handle additional patients in the face of budget reductions and reduced staffing? Our experience has demonstrated to us that when IHS or the Congress expands the beneficiaries, there is no concommittment increase in the funding levels. A clear example of this is the implementation of regulations a year ago that expanded IHS beneficiaries to include non-Indian husbands. The implementation of these regulations in terms of services to non-Indian husbands have cost the Service Unit approximately $50,000.00 which has had to be absorbed along with budget reductions. This is an untenable position, IHS and the Congress cannot continue to increase the total number of beneficiaries with no increased funding. The result of the such actions is an erosion in the quality and quantity of health care services for Indian people and represents an abrogation of treaty and trust responsibilities.

9. In 1976, in testimony presented before the Indian Policy Review Commission's Task Force on Indian Health, I testified that we had six (6) White Mountain Apache students pursuing some type of Health Career. In 1979, I was able to testify before the House and Senate Appropriation Committees that we had twenty-nine (29) students pursuing Health Careers. Today, I take pride in reporting that we presently have fifty-five (55) students pursuing Health Careers at sixteen (16) Colleges and Universities. This is a dramatic improvement in the achievement orientation of our White Mountain Apache students and is a direct result of the efforts of our Health Careers program. But funding for this program under Public Law 94-437 has been eliminated and the program is being phased out. The students are being left high and dry to face the prospect of returning to our Reservation which is facing staff reductions in both IHS and Tribal Health programs. I am embarrased to tell them they followed empty promises but it seems that we have all had to swallow our share of empty promises in recent months.

Gentlemen, I am sorry to close my testimony on such a pessimistic note. We are grateful to the Congress and Indian Health Service for their role in our accomplishments over the past few years but I see little cause for optimism under the present Administration's proposed budget reductions. What I see is a dream rapidly fading.

White Mountain Apache Tribe

HEALTH AUTHORITY

February 12, 1982

Senator Dennis DeConcini
United States Senate
Washington, D.C. 20510

Dear Senator DeConcini:

My experience over the last three years of working with the problems of Alcoholism and Alcohol Abuse of the White Mountain Apache Tribe as Director of the White Mountain Apache Tribe's Detoxification Program and as Director of the Whiteriver Service Unit's Alcohol Program have given me some insight into these problems. I have several comments and recommendations which grow out of this work.

The treatment of Alcoholism is inadequately addressed in Indian Country. The Indian Health Service has named Alcoholism and Alcohol Abuse as the "Number One" health problem of the Indian people since the early 1970's. However, the Indian Health Service facilities do not treat Alcoholism. They deal only with the massive but late medical-health and social complications of the disease.

The Indian Health Service provides funds to Indian Tribes for Alcoholism services, but these funds are pass through funds from previous National Institute of Alcohol and Alcohol Abuse program. As such they have no necessary connection with Indian Health Service hospital and clinic services. In fact in Whiteriver, the hospital and Tribal Alcohol Program have historically been at odds with one another despite memorandae of agreement. To my knowledge, the same applies to other similar Indian programs. Each program views the other as ineffective and doing the wrong thing.

Indian Alcohol Programs suffer from lacks. They lack funds to provide comprehensive treatment and are thus forced to address only one area of the problem or to inadequately address many areas. They lack guidance and support. Because of the actual low priority placed on Alcoholism, Indian Health Service consultation and guidance is not present. Phoenix Area for example, has one staff person whose responsibility is to administer the contracts, evaluate performance, and

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provide training and technical assistance for the thirteen (13) Indian Alcohol Programs spread out over Arizona, Utah and Nevada. When his travel is restricted as it often is, his value is nearly eliminated. And finally, the contracts amounts for the programs are grossly inadequate. Contract awards have not allowed staff salary increases for nearly a decade. Staff are underpaid, rapidly reach exhaustion and burnout because of lack of support, and it becomes increasingly difficult to recruit and retain qualified and dedicated personnel. The programs suffer, treatment suffers, the programs begin to look foolish to the community and the alcoholic loses.

The Tribes have their own problems with Alcoholism. Fear, ignorance, denial, economics and politics make Alcoholism a very unpopular topic. The situation is no different from that in the dominant society, but the lack of effective treatment, the divisiveness of treatment that is available and the absence of consistency leaves Indian people with a sense of hopelessness about alcoholism that will be fatal if it continues.

The Indian Health Service should direct its resources to the treatment of Alcoholism. The Indian Health Service hospitals should be directed to develop and provide in-patient primary treatment for alcoholic patients. This would consist of in-patient detoxification where necessary and a 7-10 day program of alcoholism treatment using the resources of the existing departments. By leaving primary treatment to the Indian Health Service hospitals, the Indian Alcohol Programs could focus on residential treatment, out-patient treatment and prevention/education. A long range treatment plan for each alcoholic would be developed by the resource people in the hospital and the community. Indian Health Service services would then automatically complement community resources rather than compete with and duplicate them. Consistency and cooperation would then be a possibility.

With consistency and cooperation, a unified treatment approach is possible and the chance of success is maximized. With consistency and cooperation and success, the chance of longevity is the greatest. If these goals can be realized fear, ignorance, and denial can be eliminated and the economic and political sanctions for the continuance of Alcoholism can be reversed.

The Indian Health Service must take the lead. Alcoholism is a disease and belongs in the medical model. Each Indian Health Service facility needs to identify one to three professionals who can devote full time or near full time to the development and administration of Alcoholism treatment services. These professionals should be detailed to the Tribe with dual responsibility to the Indian Health Service and the Tribe to bridge the gap and maximize cooperation. These professional positions could come out of existing positions and should be guarantee the longevity of the program and the committment.

Alcoholism is clearly the primary health problem of Indian people. It is time to orient the Indian Health Service to that reality, to treat Alcoholism and not merely the complications of the illness. Otitis media, Diabetes Mellitus, Tuberculosis, Rheumatic Heart Disease among others have had their turn. Alcoholism is treatable!

Sincerely

T Mueller

Dr. Timothy Mueller, M.D.
Executive Director
Alcoholism Program

THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE

DEPARTMENT OF MEDICINE
Division of Geographic Medicine

Please address reply to
THE JOHNS HOPKINS UNIVERSITY
INFECTIOUS ENTERIC DISEASE STUDY CENTER
C/O PHS INDIAN HOSPITAL
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WHITERIVER, ARIZONA 85941

February 8, 1982

Senator Dennis DeConcini
United States Senate
Washington, D.C. 20510

Dear Senator DeConcini,

This letter is to express my concern about the high incidence of diarrhea in The White Mountain Apache Reservation. Most of these diarrheal diseases are as a result of contamination of water supply due to inadequate sewage and solid waste disposal on the reservation.

The Johns Hopkins University has been funded for a 5 year project to study the problem of diarrhea in this tribe. The project has been in operation for 1 year. In this short period of time, it is clear that the incidence of diarrhea in this reservation is well above the national average and approaches the incidence of the disease in some of the developing countries. It is the leading cause of clinic visits and hospitalization on the reservation during the summer months. There were two deaths related to diarrhea in the past 6 months on the reservation. In addition, many of the infants suffer repeated attacks of diarrhea (some as many as 15 - 20 times per year), which has an adverse effect on their nutritional status and their ability to fight infections.

Most of the organisms causing the diarrhea are transmitted by water. The major source of contamination of the water are from sewage and solid waste.

It would therefore be of immense health benefit (and in the long run a cost saving measure) to this community if arrangements can be made for proper sewage and solid waste disposal. It would be particularly appropriate to make these changes at the present time since The World Health Organization has declared 1981 - 1990 as, "The Decade of Clean Water". The goals of their efforts are to provide clean water to all individuals in the world. It would only be reasonable for U.S.A. to take the lead in making sure that all the people in U.S. are provided clean water.

For the reasons I have stated above, I urge you to support the funding requested by The White Mountain Apache Tribe for sewage and solid waste disposal.

Sincerely yours,

M. Santosham

M. Santosham, M.D., M.P.H.
Resident Director

cc: Carla Baha-Alchesay
Charlie O'Hara

Senator DeConcini. Next, the Fort McDowell Indians, and Mr. Norman Austin, president.

Mr. Austin, it is a pleasure to have you here and be on speaking terms again since the alternative to Orme Dam has been settled. We welcome you here just as we did in those trying days. Please, proceed.

Mr. Austin. I never wanted to see you again. I thought in Washington it would be the last time, but here I am facing you once more.

Senator DeConcini. Welcome.

STATEMENT OF NORMAN AUSTIN, PRESIDENT, FORT McDOWELL INDIANS

Mr. Austin. It is a pleasure, Mr. Chairman.

We have a small reservation out there of approximately 390 people. With this Indian Health Service cut, I was informed just a couple of weeks ago that we were operating under a 20-percent cut. The Fort McDowell people are working under 32 hours a week at this time. With this service cut we cannot operate. We have the elderly and young that do not have transportation, and with two CHR's we have to transport these patients into PIMC, the Phoenix Indian Medical Center, so this is what we are faced with right now. In line with these cuts, it is coming to the point where we are going to have to lay some people off right now and shut down some hours.

We have quite a few elders, which I have mentioned, and just within this last week two elders passed away because of the cuts. The workers were informed that they had to be laid off, or whatever, and some of the people's relatives, whatever, went to these two workers, and they said they were informed they were not working anymore, and this is why we had two elders pass away within the last week. It hurt us a lot.

Senator DeConcini. Mr. Chairman, let me get a little more specific. What particular services were cut off?

Mr. Austin. The CHR's.

Senator DeConcini. No one to come and visit them?

Mr. Austin. No service on weekends.

Senator DeConcini. How often were they receiving the service?

Mr. Austin. Approximately 34 hours a week.

Senator DeConcini. Was that taken away?

Mr. Austin. No, we have cut back the hours and gone to 30 hours a week.

Senator DeConcini. And as a result there was no care?

Mr. Austin. There was no attendant, whatever, so that is what we are facing at this time.

Even though we do get some medical attention, we have to use our own tribal funds to pay off the ambulance or the helicopter if we have to fly a patient to the Phoenix Indian Medical Center.

Senator DeConcini. What distance is that?

Mr. Austin. Approximately 36 miles.

With our education—I've passed the papers around—that has all been cut, too. It has affected our reservation, too.

Senator DeConcini. You have been advised, I see from your statement here, that your school will close.

Mr. Austin. Right.

Senator DeConcini. The end of this year; is that correct?

Mr. AUSTIN. Right.

Senator DECONCINI. How many students are involved?

Mr. AUSTIN. There are under 23 little children right now.

Senator DECONCINI. Elementary?

Mr. AUSTIN. Preschool. Getting ready to enter kindergarten.

Senator DECONCINI. What school facilities are there now?

Mr. AUSTIN. Just the preschool.

Senator DECONCINI. Where do the other students attend school?

Mr. AUSTIN. Well, from there they go into Fountain Hills and on to the Mesa Schools.

Senator DECONCINI. There will be no preschool available anyplace, even given transportation; is that right?

Mr. AUSTIN. Right.

Senator DECONCINI. There is no place to send them; even if you wanted to send them to Fountain Hills, they have no preschool?

Mr. AUSTIN. No. We were sending these little kids on to the first grade from kindergarten. For the past 7 years they have been doing very well in school, but now they have to wait until they are 6 years old, and they go in there and—well, we will have quite a few dropouts, and that has been happening.

Senator DECONCINI. How long has this preschool been going on?

Mr. AUSTIN. It has been going on for 7 years.

Senator DECONCINI. Has the dropout rate in those 7 years decreased at all because of the schools?

Mr. AUSTIN. No, none at all.

Senator DECONCINI. I wonder if you understood my question. After the preschool program that you have had, is the dropout rate in grammar school or high school less?

Mr. AUSTIN. I would say it has been less.

Senator DECONCINI. Anybody have any questions?

Mr. MULKEY. Do you have a position or reaction to the Colorado River tribes proposal establishing blood quantum standards?

Mr. AUSTIN. I am sure we will look into it.

Senator DECONCINI. Very good. Thank you, Mr. President. We appreciate your being here.

Next we will hear from the Fort Mojave Indian Tribal Council, Llewellyn Barrackman, chairman, and Don O'Brien, director of health services.

Mr. O'BRIEN. Senator, Mr. Barrackman was unable to be here today, so if I may make the statement. I am Donald O'Brien, director of health services.

Senator DECONCINI. Please proceed.

STATEMENT OF DON O'BRIEN, DIRECTOR OF HEALTH SERVICES, FORT MOJAVE INDIAN TRIBAL COUNCIL

Mr. O'BRIEN. In a letter dated January 20, 1982, from the director of Indian community resources, it states, and we quote:

> This letter forewarns you that the latest congressional information received by the Phoenix area is that there will be a 20 percent funding reduction for Fiscal Year 82 on all tribal contracts and grants funded through this office.

The target for these cuts are clinical services, more specifically the CHR and health department funding.

With regard to procedures for implementing fiscal year 1982 budgets, it appears that IHS has ignored congressional intent and has expropriated tribal funds and will apportion these funds as it sees fit, vis-a-vis the 20 percent across-the-board reduction of allotment for CHR and clinical services. This not only jeopardizes the priorities established by tribal mandates but has nullified tribal self-determination.

With regard to tribal health plans, we have assessed the ineffectiveness of IHS program planning and data purported to provide guidelines for spending and projecting Federal dollars to meet tribal health needs. The intent was good, but the bureaucratic process has made these for the most part a meaningless, expensive tribal exercise. We were led to believe that Congress would view these plans as tools and as a mechanism to assure that moneys would be made available to meet individual tribal priorities. What has happened to this annual negotiating mechanism that was meant to improve communications between Congress, IHS, and individual tribes?

In 1980 in a report prepared by the staff of the Office of the Inspector General, Department of H/H/S regarding IHS management, it states that:

> Overall impression of the Indian Health Service is that it is a classic example of an organization that tries to be all things to all people. IHS suffers from a number of management problems such as conflicting goals, lack of priorities, poor communications, and other serious problems—indeed, we find that presently the IHS has neither the staff, management systems, nor resources to succeed.

It has been said many times and many ways that we, the tribes, will never reach resolution of our health delivery problems until the tribal governing bodies understand the IHS budget process. How can we establish goals and priorities if we do not know how our moneys are authorized and apportioned.

The Fort Mojave Indian Tribe is not large in numbers. This fact, combined with the geographic isolation of the people makes it difficult or even impossible to provide a full range of direct services on the reservation in a cost effective manner. Thus, when IHS balances the needs of the Fort Mojave Tribe against those of larger tribes in the Phoenix Area, Fort Mojave is of necessity always at a disadvantage for receiving their allotment of funds for health care services.

The disadvantage at which the Fort Mojave Tribe finds itself when competing for health care IHS funds is increased when the overall level of funding is cut back, as has been the case in recent years. The tribe is also affected in a major way by the chronic under-funding of IHS contract health services. Being heavily dependent on CHS for its care, the tribe suffers especially from the administrative problems which beset CHS throughout the Phoenix Area. This includes the absence of prospective CHS budgeting, which consistently results in a depletion of funds before year's end. This, in turn, leads to arbitrary cutoffs to CHS care. Fort Mojave is left then with literally no way to get the bulk of needed care. This is the case no matter how carefully local planning for CHS expenditures may have been carried out on the reservation.

Unlike direct care, there is no entitlement of Indians to CHS care. Furthermore, tribes are not given control over the management of CHS funds. Thus, there is little that Fort Mojave can do at present to help itself in the face of problems that are created through administrative decisions made at the area office level.

The equity health care fund is being increased by almost 72 percent, but IHS, as administrator of these funds, has not examined ways to more equitably distribute tribal allowances.

We therefore believe that the budget reductions demanded by IHS will cause severe shortages in health care delivery at Fort Mojave and will therefore result in even greater health, social, and economically depressed conditions. We request that Congress restore clinical service moneys to the Fort Mojave Tribe at the fiscal year 1981 level and that the continuing resolution will provide budget authority for all Federal agencies to operate until the end of fiscal year 1982.

Senator DECONCINI. Thank you, Mr. O'Brien, you make reference here, apparently, that under CHS programs when they are not annually funded, it is difficult to plan out. Can you give me an example. What do you do? Are you notified 30 days ahead of time or 1 week ahead? Instead of getting your one-twelfth you were going to get, you were going to get less? Is that what happened?

Mr. O'BRIEN. First of all, we are now into the second quarter and we still have not been given a definite budget for CHS care.

Senator DECONCINI. You mean for the year?

Mr. O'BRIEN. For the year.

Senator DECONCINI. So what have you been receiving; one-twelfth of what you think you are going to get?

Mr. O'BRIEN. Well, it started off 2 years ago with an actual expenditure of $252,000. Last year we received $216,000 and this year we have not received anything in terms of a final bottom line figure.

Senator DECONCINI. What you have received on a monthly 12-month proration, what does it prorate out? Have you received the same amount every month so far?

Mr. O'BRIEN. I would have to say that it has been reduced by probably 15 percent, and my primary concern here, of course, is that when we have $30,000 cut from a $150,000 clinical service budget, you can see the hiatus here because we were cut on contract care and the CHR program was used as a preventive-type program, to intercede, and if that has been cut, then, obviously, it affects the other program.

Senator DECONCINI. Thank you, very much.

Now the Fort Yuma Quechuan Tribal Council, Vincent Harvier, president. Is he here?

Now the Fort Yuma Quechuan Tribal Council, Vincent Harvier, president. Is he here?

Then we will go on to the Havasupai Tribal Council, James Uquilla, chairman.

Good morning.

Mr. UQUALLA. Good morning.

I do not have a copy of my testimony and I am wondering if you have it before you.

Senator DECONCINI. Yes, we received it. Thank you.

STATEMENT OF JAMES UQUALLA, CHAIRMAN, HAVASUPAI TRIBAL COUNCIL

Mr. UQUALLA. My purpose this morning is to bring your attention to the predicament that the Havasupai Tribe is in because of the issues that we are addressing this morning.

Mr. Chairman, we have met here to discuss cuts in the Indian health funding, which reflect a larger, antipeople philosophy of this administration. We who least can afford it bear the brunt of this unfortunate philosophy.

As your colleague Morris Udall pointed out recently, the Indian people, whom all people generally concede are the most impoverished in this country, have been receiving 20 percent less in governmental services than the national population.

Infant mortality among Indian people is 16 per thousand. For the general American public it is 12. Indian maternal deaths stand at 7 per thousand, while they stand at 5 for the general American public.

Our community is unusually isolated and vitally dependent on having complete health services locally available. While one of us could afford the 3 or 4 hours to reach these services for routine needs, in emergencies beyond the capacity of our local clinic, we must depend upon helicopter evacuation. Last year we saw 35 such evacuations.

A physician's assistant runs our clinic, which saw 2,686 visitors last year. Of these 15 percent involved diabetic-related problems, which is our largest single health problem, 9 percent were due to trauma and wounds and could be life-threatening without adequate local treatment.

To extend its health care services, the Havasupai Tribe operates a community health representative program. We have a corps of six paraprofessional local people who offer homemaker services, personal care, environmental health maintenance, dental assistance, health education, infant care, home deliveries, and medical recordkeeping.

Our community health representatives make over 6,000 contacts with community people. A third of their contacts involve some form of personal care for our people. A third of their contacts are with old people, and 10 percent involve infants under 1 year of age. A third of their contacts occur in the home. As you can see, Mr. Chairman, the CHR program greatly extends and enhances the services of our local clinic.

Our health task force includes a group of concerned local people who advise on community health needs. Additionally we offer training for our CHR's in the hope that they may one day act as professional health care employees.

Through the health department we offer nutrition services, alcohol counseling, and social service. We have a three-quarter time health department director and she has a quarter-time assistant to coordinate all these services.

For such a small program the 20-percent cut we are being asked to make will fall heavily. How shall we distribute such cuts? Shall we reduce direct services to our people? Shall we cut further an already overtaxed administrative staff? Shall we end CHR training? Sadly, we face such alternatives. Twenty-percent cuts will force us to eliminate one CHR altogether for homemaker services to the elderly. We shall have to eliminate the health department director's assistant. We shall have to cut further training on CHR's and we shall have to disband our health services task force. Where will it end? We have already seen one recommendation to close our clinic altogether. Where would we turn?

The United States is neither poor nor underdeveloped, yet we are being asked to tighten our belts while we see the Nation's wealth diverted to those without want—the military producers, oil companies, big business. A Nation which fails to provide adequate health and social services to all its people is misallocating its resources. And it is that simple, Mr. Chairman.

That concludes my oral presentation.

Senator DECONCINI. Thank you very much. I have no questions. You point out some very interesting statistics in the second paragraph on your first page. I think those will help us. We are going into hearings February 25 and 26. Hopefully, we can also pose some of those questions, not only to IHS and BIA, but maybe to OMB, to find out—it seems to be a good case here for buck-passing and I would sure like to see where the buck stops. Maybe we can achieve that.

Mr. UQUALLA. I just wonder if you get the impact of some of the isolation that some of the tribal groups have within the Arizona tribes. The Havasupai has to be one of the most isolated and smallest in number of the reservations, and that is the impact I would like to get across. They have a very great need for those direct services in those communities, especially the ones that are isolated, and we are going to get into additional problems and right now we are not meeting those services.

Senator DECONCINI. I am very aware of your physical isolation and geographical circumstances, and you make a very good point that I think this record maybe addresses and which will be influential with other members of this committee and of the Senate to demonstrate the need to not curtail all of these services.

Mr. UQUALLA. Additionally, I would like to echo the chairman for the White Mountain Apache Tribe in reference to the recommendations that the Colorado River Tribes has made. The Havasupai Tribe will endorse those recommendations that the Colorado River Tribe has made. It would affect the Havasupai Tribe very little if you want numbers. We are looking at two or three individuals if that is implemented, but we do endorse it.

Senator DECONCINI. Thank you very much.

Your prepared statement will be placed in the record at this point.

[The statement follows:]

PREPARED STATEMENT OF THE HAVASUPAI TRIBE, SUBMITTED BY JAMES UQUALLA, CHAIRMAN

Mr. Chairman, we have met here to discuss cuts in Indian health programs. These cuts reflect a larger, anti-people philosophy of this Administration, and those citizens already least served by federal health and social programs will bear the brunt of this unfortunate philosophy.

As your Congressional colleague Morris Udall pointed out in a speech last May 4,

> "* * * the average per capita expenditure per Indian from all sources—federal, state and local, and tribal—was $2947.82 in FY 1980 . . . For that same year, the national average per-capita expenditure was $3687.61 . . . the Indian people, whom all people generally concede are the most impoverished in this country, have been receiving 20 percent less in governmental services than the national population."

Infant mortality among Indian people is 16 per thousand. For the general American public it is 12. Indian maternal deaths stand at 7 per thousand, while they stand at 5 for the general American public. Death rates from all causes among the American people stand at 7 per thousand; for Indian people they stand at 7.5 per thousand, and for the Havasupai people they usually stand above 10 per thousand.

The Havasupai community is unusually isolated and vitally dependent on having complete health services locally available. Three hundred fifty people live in this community on the bottom of a 3,000-foot-deep canyon at the end of an eight-mile foot trail without alternative health care. The nearest clinic other than our own lies 70 miles away, and the nearest towns with hospitals, Flagstaff and Kingman, lie 170 and 180 miles distant respectively. While a person could afford the three or four hours to reach these services for routine needs, in emergencies beyond the capacity of our local clinic we must depend upon helicopter evacuation. During the past year we saw 35 such evacuations.

The Havasupai health care program centers in a Tribal health department and an Indian Health Service clinic staffed by a single IHS physician's assistant. This PA can handle all routine cases and deal with certain emergencies. Annually our clinic handles 2686 visits. Of these, 18 percent represent routine preventive care, but 15 percent deal with diabetes-related problems—our largest single health problem. While 14 percent of our clinic visits involve dental care and 13 percent relate to colds and upper respiratory ailments, fully 9 percent of Havasupai clinic visits are due to trauma, lacerations and wounds—potentially life threatening without adequate local treatment.

In addition to the IHS clinic and professional staff, the Havasupai Tribe operates a highly-important program to extend its health care services: the Community Health Representative program. Under the CHR program, we have a corps of six paraprofessional local people who perform health-related work in homemaker services, personal care, environmental health maintenance, dental assistance, health education, infant care, home deliveries and medical record keeping.

During a given year our CHRs will make over 6,000 contacts with community people. Over 35 percent of their contacts involve some form of personal care for our people, both at home and in the clinic. Our CHRs make a third of their contacts in home visits. Our CHRs make a third of their contacts with old people, who require the flexible and specialized attention of local health providers familiar with the Havasupai language and culture; fully a quarter of CHR contacts on our reservation relate to the problems of old age. Twelve percent of CHR contacts deal with diabetes, and ten percent involve infants under a year of age. Over 20 percent of their contacts represent routine but helpful home deliveries of medication as well.

As you can see, Mr. Chairman, the CHR program greatly extends and enhances the services of our local clinic.

Our health department includes a group of concerned community members, the Havasupai Health Task Force, who meet to advise our health department and health providers on community health needs and wishes as they arise. Additionally we provide training through our Tribal health department for our CHRs to bring them up to professional capacity. We do this with the hope that these dedicated people may one day provide professional health care to their own community.

The Havasupai Tribe also provides nutrition services through the Women, Infants and Children (WIC) program, through Summer Feeding and Title III and Title XX of the Older Americans Act. We have initiated a much-needed counseling and alcoholism program.

An overworked, three-fourth time Health Department Director coordinates all this along with our social services. For assistance she has only a one-fourth-time administrative assistant.

Considering what they mean to the well-being of our people, the costs are minimal.

Our clinic and physician's assistant cost the government less than $50,000 a year. Operating the Havasupai Health Department and CHR program costs $108,000. Our WIC program costs $4400 a year. Title III and Title XX feeding and homemaker services cost $11,000 a year. Our counseling and alcoholism program comes to $20,000, and our social service program we operate for $9,500.

The twenty percent reductions we are now being asked to make will fall heavily upon our small health department. From an already overextended program we must subtract $22,000. How shall we distribute such cuts? Shall we reduce direct services to our people? Shall we cut an already overtaxed administrative staff still further? Shall we end further training for our CHRs? Shall we short-circuit the community's involvement in health service planning and thereby short-change the community itself?

Sadly, we must face such alternatives. To comply with the 20 percent funding cuts and still maintain a viable health program, we have eliminated our newest CHR position altogether—that to provide homemaker services to our old people. This represents a reduction in direct health care service to our people.

We have eliminated the Health Department Director's administrative assistant, leaving her without the assistance she so vitally needs.

We have cut all further training and travel for our CHRs.

We have eliminated further reimbursement to our health task force members for attending meetings. Many of these people work and will now find it a hardship in our low-income community to take time off their jobs to attend such meetings. In fact we fear it will result in the disbanding of our health task force.

And where will it end? Will this Administration ask our physician's assistant to limit his time to a 40-hour week? We know this would be unreasonable to expect of medical personnel, but we wonder if this Administration knows it. Will the Administration ask our clinic to reduce or stop distribution of over-the-counter medication? If this happens, a community like ours has no corner drug-store to resort to. Will this Administration limit medical emergency air evacuations to 25 a year? What happens to the 26th emergency?

These are some of the questions the current social budget cuts raise in our minds.

The United States is neither poor nor underdeveloped, yet we are being asked to tighten our belts while we see the nation's wealth diverted to those without want—the military producers, oil companies, big business. A nation which fails to provide adequate health and social services to all its people is misallocating its resources. It is that simple, Mr. Chairman.

Senator DECONCINI. I am going to leave at this time, but we will continue. Mr. Mulkey will conduct the remainder of the hearing. The staff will ask questions.

We will now hear from the Hopi Tribal Council. If you will come forward, please.

Mr. MULKEY. If you would like to comment.

Mr. SIDNEY. Mr. Mulkey, Mr. Taylor, and the other gentleman, I was going to say three things in my own language, but I do not want to give this lady problems.

Mr. MULKEY. Please, identify yourself.

STATEMENT OF IVAN SIDNEY, CHAIRMAN, HOPI TRIBAL COUNCIL

Mr. SIDNEY. Mr. Chairman and members of the committee, I am Ivan Sidney. We have a written report here which we are entering into the record of these proceedings. It is attached and we would like it considered as a part of these general remarks which I want to present to the committee at this time.

When the fiscal year 1982 budget was prepared, the appropriate conference committee of the Congress rationalized that increased direct services provided through new and replacement hospitals and clinics and associated staffing increases should reduce the need for CHR's. The committee directs that the reduction below the fiscal year 1981 level be solely applied to those areas which have increased medical staff in fiscal years 1981 and 1982 as a result of new construction. There has been no new construction, modernization, or staff increases in the service unit supporting the Hopi Indian Reservation, yet we have received the same 20-percent reduction applied to all units.

Mr. Chairman, I would also call your attention to the fact that the provisions of Public Law 96–305 are, among others, that the Hopi Tribe is to receive a health complex and hospital and a junior-senior high school. For their part, the Indian Health Service and the Department of Health and Human Services have shown little appreciation of the intent of the Congress as expressed in Public Law 96–305. Given compliance with Public Law 96–305, the management and budget decisions required of the departments which affect the Hopi Tribe might have more options and alternatives in absorbing changes. You are urged to exercise appropriate oversight to get the processes authorized by Public Law 96–305 moving.

As mentioned, the attached formal report provides statistical and other documentation, especially in the areas of preventive health services, alcoholism programs, and clinical services. Please give careful consideration to these matters.

This committee is frequently reminded of trust responsibilities and the special relationship that exists between the U.S. Government and the Indian tribes. In recent years, unfortunately, trust responsibilities and special relationships have apparently become more and more identified with acres of land and dollars. These are of course important. However, the Indian people are the basis of both the special relationship and the trust activities.

The Federal responsibilities are for shelter, food, health, and education. From the need to fulfill these responsibilities flow the dollar appropriations and their administration. In recent years, the Federal approach has appeared to be more and more one of asking how many dollars do we have and then determining the responsibilities. The responsibilities, gentlemen, are written in treaties, agreements, and the statutes of the United States. The matters being addressed by this hearing appear to have, unfortunately, placed responsibilities secondary to dollars.

Thank you for your courtesy and the opportunity to appear before you today.

Mr. MULKEY. Thank you, Mr. Chairman.

Has IHS given you any reason why you were asked to take a 20-percent reduction in your CHR program when apparently the language in the conference committee report might indicate that something else should be done with respect to your programs?

Mr. SIDNEY. Apparently, the directives have come from the central office level, and this is our understanding, to date, on what is happening.

Mr. MULKEY. Have they not said why or tried to explain?

Mr. SIDNEY. No, sir; not in any detail.

Mr. MULKEY. What is your reaction to the Colorado River Tribes' proposal as far as eligibility of established blood quantum?

Mr. SIDNEY. We, on the Hopi Reservation, have a constitution that we have been following, and the constitution clearly sets forth, if you are speaking of the membership—is that what you are speaking about?

Mr. MULKEY. Yes, but do you tend to support the Colorado River Tribes' proposal? Just give us your general views on it.

Mr. SIDNEY. Yes.

Mr. MULKEY. You support it?

Mr. SIDNEY. Yes; anything to get the Indian people better services in health care.

Mr. MULKEY. Do you have any idea of the impact such proposals would have in your area in terms of people that might not receive services they are presently receiving—numbers or anything like that?

Mr. SIDNEY. It would affect our reservation considerably, and I notice the tribal leaders ahead of me keep talking about isolation factors. Those seem to come into one's mind immediately. The fact that we are the most northern area and we are faced by that; and we have to provide services to those people that come on our reservation in that area, and we do not have any surgical unit in the area.

For example, if anyone were to be involved in an automobile accident, it would take a half hour to report it to the nearest law enforcement, another 45 minutes for the ambulance to come, and a return trip, if that individual needs special attention, to the airport 12 miles away and then flying off to Phoenix. That is the type of isolation we are talking about, so anything that would hamper immediate health care would affect us very much.

Mr. MULKEY. In your statement, you mention Public Law 96–305. I think both Pete and I are kind of familiar with that. It is my understanding from what you have said here that no action has been taken on the requirement that these shall be given—both the school and the clinic—the highest priority; is that accurate?

Mr. SIDNEY. As I understand, to date, just this morning, that item is in the Secretary's office right now. There seems to be a question on it, where the priority is, and at this time, the Secretary's office is looking into that. We would appreciate this committee's inquiry into that immediately, recognizing the priority and letting of $800,000 that we are talking about.

Mr. MULKEY. I am sorry. Go ahead. Which one are you talking about, the clinic or the——

Mr. SIDNEY. The hospital. I believe Pete Taylor and I have talked about this recently.

Mr. MULKEY. Thank you.

Your prepared statement will be made part of the record at this point.

[The statement follows. Testimony resumes on p. 395.]

HOPI TRIBE

TESTIMONY TO THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

Indian Health Service Oversight Hearings

Phoenix, Arizona

February 15, 1982

Mr. Chairman, Members of the Committee: I am Ivan Sidney, Chairman of the Hopi Tribe of Northern Arizona.

The Indian Health Service, responsible for providing health care to the Indian people under the Snyder, Transfer, and Indian Health Care Improvement Acts, is faced with cutbacks due to the Fiscal Year 1982 budget reductions. I would like to discuss the effect these and subsequent budget cuts will have on the provision of health services and the development of health care management capability for the Hopi Tribe.

The overall Indian Health Service budget for FY 1982 (excluding Construction) was not reduced substantially, yet the following has occurred in Preventive Health Services, Alcoholism Programs, and Clinical Services on the Hopi Reservation.

Preventive Health. Despite the emphasis on Preventive Health and Health Promotion by the Secretary of Health and Human Services, Richard Schweiker, all of the Indian Health Service's Preventive Health programs will suffer from decreased funding. However, none as much as the Indian community-based programs funded under the Community Health Representatives line item, where the majority of Tribal Health Departments receive their funding. This program, which has been cut by 20.7 percent for FY 1982 and eliminated from the proposed FY 1983 budget, has provided the framework for Hopi tribal health care management and Hopi-oriented community and prevention based programs.

When developing the FY 1982 budget, both the Senate and Conference Committees rationalized that "increased direct services provided through new and replacement hospitals and clinics and associated staffing increases should reduce the need for CHRs. The Committee directs that the reduction below the FY 1981 level be solely applied to those areas which have increased medical staff in FYs 1981 and 1982 as a result of new construction". The Indian Health Service ignored Congressional intent, and has directed that the 20.7 percent reduction to CHR programs be applied to all Areas.

I wish to point out that there has been no increase in medical staff or new construction on the Hopi Reservation in FYs 1981 or 1982. The Hopi Health Department, providing supportive health and human services to the Hopi people not provided by the Indian Health Service or the Bureau of Indian Affairs, has been directed to reduce it's contract by 20 percent for FY 1982. This reduction will result in the loss of preventive and clinical health services which was not nor will not be provided by the Keams Canyon Service Unit Hospital.

This $163,296.00 reduction in the Hopi Health Department's budget has resulted in:

1. The loss of nine filled positions;
2. The loss of pay increments of $500.00 per year for 54 staff;
3. The loss of holiday and differential pay for Emergency Medical Technicians;
4. A 20 percent reduction in salaries of all staff, excluding EMTs; and,
5. A 37 percent reduction in the operating budget of the Health Department.

This could result in the destruction of the administrative and service structure of the Hopi Health Department, developed with the assistance of the Indian Self-Determination Act, especially when the proposed FY 1983 budget is considered. The proposed FY 1983 budget would eliminate more than 40 employment opportunities for Hopi people, destroy the capacity of the Tribe to take over IHS programs and eliminate the following emergency and preventive health services provided by the Health Department.

The Hopi Health Department provides emergency medical services for the entire Hopi Reservation and portions of the Navajo Reservation. This state-certified model emergency medical services program has been developed over a period of eight years, almost entirely with CHR funds, from the Indian Health Service. During FY 1981 the Hopi EMS provided these services to the Indian Health Service and the Hopi people:

1. 202 Emergency Ambulance runs;
2. 875 Emergency Room Vists for emergencies;
3. 159 Transports to other facilities for surgery or births;
4. 11,000 of the 30,000 Outpatient Visits for the Keams Canyon S.U. due to the lack of outpatient nursing staff; and,
5. Developed a First Responder System among community members to reduce the 60 minute emergency response time.

These services will be eliminated with the proposed FY 1983 budget. The program has been compromised with the FY 1982 budget, by freezing salaries, disallowing differential pay, eliminating funds for re-certification, and preventing the implementation of a centrally located emergency medical services station on Second Mesa. This centrally located station would have reduced the response time for emergencies on the Hopi Reservation to 30 minutes. Indian Tribes are ineligible to receive funds for EMS under the Preventive Health Block Grants.

The Community Health Services, with Community Health Representatives, provides the following patient care services to the Keams Canyon Service Unit:

1. Home Health Care, Discharge Planning and Followup, due to the lack and inclination of the Community Health Nursing Staff to work in the communities;
2. Staffing for Second Mesa Clinic, the only centrally located health facility for the Hopi people. The CHRs have enabled the clinic to still remain open two days per week after Service Unit budget cutbacks;
3. Optometry aide for the Optometry Department of the Hopsital; and,
4. Nursing Home ombudsmen services to the 25 Hopis placed in off-reservation nursing homes, due to the lack of extended care facilities on the Reservation and the reluctance of IHS and BIA staff to work with families and clients to retain Hopi elders in their communities; Sometimes, IHS and BIA staff feel it is easier and more expedient for them to place elders in nursing homes rather than working with families to care for their elders.

The Health Department has been instrumental in providing Hopi-specific Health Education classes in the reservation grade schools in Environmental Health, First Aid and Accident Prevention, and recently developed an Alcohol and Mental Health Education curriculum to be used in the schools. This activity and function is not carried out by the Indian Health Service staff due to lack of resources, lack of knowledge of Hopi culture, and reluctance of staff to work in the communities and schools.

The Alcoholism Programs received a 7 percent increase for FY 1982, yet the Hopi Alcoholism Program was directed by the Phoenix Area to reduce it's contract by 10 percent. This is in direct conflict with Congressional direction, as the program has not been evaluated.

The Hopi Tribal Council has designated Mental Health and the development of those services a high priority for the Health Department. The Department is attempting to develop community-based behavioral health services that reflect Hopi values and teachings in prevention and health, currently not provided by the Indian Health Service. The Hopi Tribe is ineligible to receive funds for Alcohol, Mental Health, or Drug Abuse Services directly under the Mental Health Services Block Grant, and the State of Arizona has already divided the funds among its existing constituents.

As I have related, the Hopi Health Department programs have not duplicated nor supplanted Indian Health Service Programs, but have been used to correct deficiencies noted in the Hopi Tribal Specific Comprehensive Health Plan developed by the Tribe under P.L. 94-437 and P.L. 93-638. Elimination of the Community Health Representatives line item funding will further exacerbate the reductions in health services to Indians caused by budget cuts, high federal pay scales, and inflation. Due to high personnel costs, the Indian Health Service could not afford to replace (within their budget), the services provided by the Hopi Health Department.

Clinical Services. Funding for the Indian Health Service hospitals and clinics was reduced by 1.5 percent. This reduction, (which did not include tne FY 1981 or 1982 Pay Acts), in the CETA programs on the Reservation, the loss of Medicare reimbursement funds, and deficit spending caused by previously inadequate funding resulted in these decreases in services at the Keams Canyon Service Unit:

1. Eight hospital beds were closed due to nursing shortages;
2. Second Mesa Clinic, the only centrally located health care facility for the Hopi was to be closed, resulting in a decrease in the availability and accessibility of primary care and preventive health services to the 67 percent of the Hopis living more than 20 miles from the Keams Canyon Hospital and increased out of pocket expenses for gasoline. The clinic, staffed with CHRs is presently operating at one half of its previous capacity;
3. Whitecone Clinic, serving Navajos living on Partioned Lands was closed;
4. Low Mountain Clinic, also serving Navajos on Partioned Lands was closed;
5. Non-prescription drugs are no longer provided and patients must purchase them at Reservation trading post prices, which are more than 2.5 times the cost at stores located 100 miles away in Flagstaff and Winslow;
6. Elimination of one physician position; and,
7. Elimination of training and educational opportunities for employees. This was essential in the recruitment and retention of medical and nursing staff to enable them to receive continuing education in their respective fields.

These reductions in services appear to far exceed the 1.5 percent budget cut in the IHS Hospitals and Clinics line item.

Contract Care. At this time, the Keams Canyon Service Unit provides health care services to the Hopi, the Kaibab-Paiutes, two Navajo communities, and a large number of Navajos from outside of the designated Service Unit boundaries. The Kaibab-Paiute utilize a large portion of the contract health care funds to receive primary care and emergency care due to their remote location and the limited services provided by the Indian Health Service. The large number of non-Service Unit Navajos receiving care at the Keams Canyon Hospital and referred to contract care services by the physicians treating these patients has resulted in inadequate contract care dollars for the Service Unit. The medical staff of the Hospital is often compromised for the sake of the monetary reimbursement system as these patients are referred back to their respective service units, often causing a delay in treatment.

This problem is caused by inadequate funding of contract care dollars and the reluctance of the Navajo Area Indian Health Service to provide additional dollars for Navajo patients seeking care at Phoenix Area facilities.

IHS Management and Tribal Involvement. On several different occasions, the Indian Health Service Area Office has issued directives to Health Department personnel regarding the Alcoholism Program. These accounts are almost always given with no,or delayed,written documentation and little or no explanation as to how or why these decisions were made. Often times, these decisions are of great importance to staff providing services to the Hopi people and involve budget cuts and modifications. Indian Health Service failure to provide written documentation has led Health Department staff to spend an inordinate amount of time requesting funding from the Tribe's master accounts to cover expenditures until authorization from IHS arrives.

Not only are IHS communications delayed but they are often contradictory. Over the last several months Health Department personnel have heard different accounts from the Hopi Alcoholism Project Officer, IHS Contracts Specialists, and IHS Contracting Officer regarding the freeze on equipment line items, and the loss of a salaried position if monies were reprogramed for other purposes. The contradictory replies to these questions were "lifted", "not lifted", or "don't know", and "it's okay to use them with no consequences", or "it's not okay to use them". This would appear to be the failure, at times, by IHS personnel to:

1. Know their information; and,
2. Acknowledge their ignorance on certain occasions, take action to find out the answers, and reply to the Tribe by phone or letter regarding the information.

These contracting problems, attributable to the IHS bureaucracy, have been presented at previous IHS oversite hearings by numerous tribes, yet it seems that IHS persists in retaining their "paternalistic role" despite the legislation and the desire of the Tribes to determine their own direction in providing health care to their people.

Implementation of P.L. 96-305. The Hopi Tribe has experienced innumerable delays in the release of $800,000.00 for the design of a portion of the Hopi Health Complex to comply with the statutory requirements of P.L. 96-305, the Hopi-Navajo Relocation Amendments Act. A history of this project begun in 1977, under P.L. 93-638 is attached to this written testimony. The decisions made by the Indian Health Service and the Department of Health and Human Services are arbitrary and capricious in nature and display a total disregard for the intent and implementation of Public Laws 96-305 and 93-638 in defiance of the United States Congress. In essence, the Indian Health Services and the Department of Health and Human Services are "self-determining" for the Hopi Tribe,who, what, and how health services will be provided now and in the future.

Recommentations. The Hopi Tribe would like to make the following recommendations regarding the Indian Health Service:

1. Reinstate the Community Health Representative Program funds;
2. Reduce the size of the Program Office bureaucracies at Headquarters and Area Offices and establish a reasonable limit on the percentage of funds allocatable to government overhead;
3. Change the government regulations that prevent the funds received from billing Medicare, Medicaid and other third party payors to the Service Units. This would improve the Service Units capability to meet their service needs and enable Indian Health Service facilities to become economically self-sufficient;
4. Trust responsibility?; and
5. The Department of Health and Human Services and Indian Health Service honor the Congressional direction provided by the Hopi-Navajo Relocation Amendments and release funds available for planning of the Hopi Medical Center.

RE: 1983 IHS Budget

The proposed FY'83 Budget (Administration) for IHS as released contains the following for Clincial Services. The Overall IHS budget has been increased by $13M from the FY'82 Budget amount. This was done by "refocusing resources from non-patient care areas to maintain direct health care". "The elimination of $29M federal funding of Tribal Staff who currently provide liaison and some health services for IHS and Indian people under the CHR program ($29M), eliminate the Urban Indian Health Program ($8M) and eliminate any new Health Manpower Programs. No new construction money was provided for FY'83, instead there is projected to be $59M in carryover from FY'82".

	FY'83	FY'82	FY'81
HEALTH SERVICES			
Hosp. & Clinics	$ 323.3	$ 305.4	$ 310.0
Equity Health Care	19.3	13.5	7.59
Dental	19.9	17.9	17.69
Mental Health	8.1	7.5	7.51
Alcoholism	20.2	16.3	15.24
Maint. & Repair	8.2	8.2	8.61
Contract Care	130.5	110.4	107.47
Total Clinical Services	$ 529.5	$ 481.2	$ 474.41
PREVENTIVE HEALTH			
Sanitation	15.1	14.1	15.09
Public Health Nursing	8.3	7.9	8.01
Health Education	2.3	2.2	2.15
CHR's	0.0	28.8	36.30
Total Preventive Health	25.7	53.05	61.55
Urban Indian	0.0	8.1	8.90
Indian Health Manpower	4.0	5.7	5.81
Tribal Management	2.6	2.6	3.03
Program Management	51.2	48.8	53.01
Total IHS Health Services	$ 613.0	$ 599.4	$ 606.71
IHS CONSTRUCTION	Carryover		
Hospitals	$ 14.3	$ 9.5	$ 25.693
Moderization & Repair	2.1	.192	3.300
Outpatient Facilities	10.04	9.613	4.456
Sanitation	32.82	27.480	50.240
Personnel Quarters	.45	.336	.780
Total IHS Construction	$ 59.0	$ 47.152	$ 84.469
TOTAL IHS BUDGET	$ 613.0	$ 646.797	$ 691.178

THE HOPI TRIBE

November 27, 1981

RECEIVED
DEC [illegible] 1981
[illegible] HEALTH DEPT.
ORAIBI, ARIZONA

In reply refer to:
Office of the Chairman

Mr. Richard Schweiker, Secretary
Department of Health and Human Services
Washington, D.C. 20202

Dear Mr. Schweiker:

The Hopi Tribe has become aware that Indian Health Service Headquarters is preparing a third Program Information Document for the Hopi Health Complex. The Hopi Tribe is seriously concerned about the additional delays that this will cause in proceeding with the Design Phase of the project.

Earlier this year, the Indian Health Service made available $800,000 of appropriated money for the design of a portion of the Health Complex to comply with statutory requirement. To date, official action has not been taken releasing this money. This is only one of many delays experienced by the Hopi Tribe in this project. The following chronology outlines what has been a very frustrating experience of the Hopi Tribal Council in attempting to fulfill one of the highest priority goals of the Hopi people.

The construction of a new centrally located Health Complex is a long term need of the Hopi Tribe. Under the Indian Self-Determination Act (P.L. 93-638), the Hopi Tribe completed a Tribal Specific Comprehensive Health Plan, which identified the need for centrally located comprehensive health services.

As outlined in the Tribal Specific Health Plan, the Hopi Tribe then completed a Feasibility Study and Facility Master Plan for the proposed Health Complex under P.L. 93-638. The Feasibility Study was the first Program Information Document which presented both the private health care sector's and the Indian Health Service's planning methods for population, facilities and staffing. This Study was approved by the Hopi Tribal Council in March 1980.

In February 1980, the Hopi Tribe had already presented testimony before the U.S. Senate and House of Representatives Appropriations Committees providing information on the number of beds, space, housing, and design and construction costs for the Health Complex. The information was concurrently submitted to the Indian Health Service.

The Navajo and Hopi Relocation Amendments Act of 1980, (P.L. 96-305) was enacted on July 8, 1980 and contains the following language:

> "... the Secretary of Health and Human Services, as appropriate shall assign the highest priority...to the funding and construction of the Hopi High School and Hopi Medical Center."

During the fall months of 1980, the staff of Phoenix Area Indian Health Service and the Hopi Tribe spent considerable time re-examining the population and workload data for the Health Complex. On October 23, 1980, representatives from the Indian Health Service (Headquarters, Phoenix and Navajo Areas, Keams Canyon Service Unit) and the Hopi Tribe met to discuss the population and workload data. The timetables established at that time have been set back time and time again for various reasons by Headquarters of the Indian Health Service.

In December 1980, the Phoenix Area Indian Health Service submitted to the Director Indian Health Service in Washington the Feasibility Study, including recommendations for approval of the Health Complex.

The Phoenix Area Program Planning and Statistics staff met with Headquarters staff in Rockville to finalize data relative to the Health Complex in January 1981.

In February 1981, the Hopi Tribe again testified before the U.S. Senate and House of Representatives Appropriations Committees presenting information on the number of beds, space, housing and the design and construction costs for the Health Complex. At that time, the possibility of reprogramming appropriated funds of the Indian Health Service was discussed.

On March 23, 1981, approval of the workload data for the Health Complex was approved by Indian Health Service Headquarters, Office of Program Statistics. However, despite numerous and frequent correspondence, approval of plans for the provision of medical and surgical services for the Health Complex did not occur at the same time as workload data. Consequently, the Tribe and the Phoenix Area Indian Health Service proceeded to prepare a second Program Information Document based on the approved workload data. This Program Information Document was completed in August 1981.

In September 1981, the Hopi Tribe became aware of the Indian Health Service's intention to prepare a third Program Information Document based on a new set of workload and population figures purportedly using 1980 Census figures. These figures do not agree with the figures provided to the Hopi Tribe by the U.S. Bureau of the Census and the Office of Revenue Sharing.

The delayed decision finally made in October 1981 by the Indian Health Service not to provide surgical capability in the Health Complex will affect the nature of health care delivery on the Hopi Reservation for generations. The small inpatient facility proposed by the Indian Health Service will deny the Hopi Tribe the ability to provide health services commonly available to other Americans within their own communities, greatly diminish the ability of the Tribe to recruit and retain nursing and medical staff, and probably present the acquisition of shared services from the growing private sector multi-institution health care consortiums.

The decisions made by the Indian Health Service and the Department of Health and Human Services arbitrary and capricious in nature and display a total disregard for the intent and implementation of Public Laws 96-305 and 93-638 in defiance of the United States Congress. In essence, the Indian Health Service and the Department of Health and Human Services are "self-determining" for the Hopi Tribe, who, what and how health services will be provided now and in the future.

The Hopi Tribe is requesting that the Indian Health Service reconsider its recommendation not to provide surgery in the Health Complex. We also strongly urge the Indian Health Service not to proceed with a third Program Information Document based on that workload data, and instead proceed with the provision of funds for the design of the Acute Care Facility phase of the Health Care Complex.

Sincerely,

Abbott Sekaquaptewa
Chairman
Hopi Tribal Council

cc: Edward N. Brandt, Jr., M.D., Assistant Secretary for Health
Joseph Exendine, Acting Director, Indian Health Service Headquarters

Mr. MULKEY. The next panel will be the Hualapai Tribal Council, represented by Delbert Havatone, chairman, and Bob Borchardt, health director.

If you would like, please introduce yourself and proceed.

Mr. WALEMA. The Senate Select Committee on Indian Affairs, before our interview or testimony—before we start, I'm Edgar Walema, tribal counsel for the Hualapai Tribe.

Mr. MULKEY. Excuse me. Could you identify this gentleman?

Mr. WALEMA. Bob Borchardt.

Mr. MULKEY. Thank you.

STATEMENT OF EDGAR WALEMA, TRIBAL COUNSEL, HUALAPAI TRIBE, ACCOMPANIED BY BOB BORCHARDT, HEALTH DIRECTOR

Mr. WALEMA. The Hualapai Tribe appreciates this opportunity to appear before you and to present our testimony. The Hualapai Tribal Council is concerned about the effect the Indian Health Service budget cuts will have on the health care for the Hualapai people and other Native Americans living in this area.

The Indian Health Service, Phoenix area office, has informed us that there will be a 20-percent funding reduction on tribal contracts and grants funded through the Office of Community Resources for fiscal year 1982.

The tribal programs that have been effected on the Hualapai Reservation are the community health representative program and the tribal health department. We have already implemented these cuts by reducing the community health representative personnel to 27 hours per week. The community health representative program performs such functions as: home nursing care of the elderly, emergency transportation, and coordination of various health provider organizations.

These functions are particularly important now because of: No. 1, no community health nursing; No. 2, reduction in Indian Health Service providing transportation, routine and emergency; and No. 3, elderly in need of home health care. These types of services will be significantly reduced. Home nursing care will be reduced by 32 percent. Example: If 80 patients are seen per week, this will drop to around 54 seen every other week.

The community health representative program transports patients to Mojave General Hospital in Kingman, Veterans' Hospital in Prescott, and Parker Indian Health Service Hospital because the Indian Health Service has only one driver available for routine and emergency driving. Some of the routine driving is to pick up Havasupai patients at Hill Top, which is 70 miles from the Peach Springs Clinic. The community health representative transports around 7,200 clients a year, and this will decrease to 4,896, and no emergency transportation.

Here are some examples of how the budget cuts have affected personnel salaries: No. 1, from $9,750 to $6,478; No. 2, from $9,459 to $6,441; and No. 3, from $8,151 to $6,042.

The Hualapai Tribal Health Department has also gone to a 27-hour workweek. The cut for this program was actually 32 percent since we are into the second quarter of the contract period. The Hualapai

Tribe has worked diligently to develop a functioning health department that would effectively advocate for tribal interest. This means that the administration function of the Hualapai Tribal Health Department will be reduced 32 percent.

This department has been instrumental in securing funds for the Hualapai tribal health programs. It has been a voice for the Hualapai Tribal Council at health meetings on local, State and Federal levels. The health department has been an advocate to the Indian Health Service to provide adequate care for tribal members and other Native Americans in the area. These functions will be reduced due to budget cut. These cuts for the community health representative program and Hualapai health department will drastically affect the overall tribal health programs on the Hualapai Reservation. The health of this community would be unimaginable and unacceptable.

The Indian Health Service has requested that all service units spend at a level of 90 percent of the fiscal year 1981 budget. The allowance of funds for fiscal year 1981 was $300,400 for direct patient care at two clinics. This year the mandate is to spend $271,704. That actual need is $373,534 for the operation of the Peach Springs health facility and the Supai Clinic.

To have stayed within this budget allocation, the Peach Springs Clinic would have had to take the following measures October 1, 1981: No. 1, eliminate two provider positions; No. 2, eliminate all overtime; No. 3, close down all Government quarters; and No. 4, only be in operation 40 hours per week without after-hours emergency services. The only other way this facility could stay within the budget guidelines is to close the facility sometime in June 1982.

These actions would also increase the expenditures of Contract Health Services; that is, buying health care from the private sector instead of providing it directly. In all reality, if there were no after-hours or weekend emergency services, patients would have to be seen at Mojave General Hospital—round trip 100 miles. The contract care funding would be depleted before the fiscal year 1982 ends.

On the field health programs with the 10-percent decrease in operating funds, we would receive 1 day of service from the nutritionist, most likely no services in environmental health, social worker, health educator, and community health nursing. Although these types of positions are allocated and funded by the Phoenix area office, a reduction at any level results in reduced service in local communities such as ours.

Before imposing such simplistic solutions as across-the-board reductions of tribal and Indian Health Service programs, we would ask the following questions: In the Phoenix area, there is the Phoenix area office, office of research and development, and the California program office. Could not two of these offices be eliminated and one area office be designated? How much savings in administration could be reallocated for direct patient services?

How much money is the Phoenix area allocated for administrative services, including administration and categorical programs? How much support and services are being provided to service units and tribes from these area office functions? Before the tribal and Indian Health Service programs are cut, administrative functions should be cut at area and other program offices.

The Hualapai Tribal Council emphatically requests that the budget cuts for the tribal programs and the Indian Health Service programs be reinstated at levels that will provide for adequate services. If this is not done, we can see that health care of the Indian people will deteriorate further.

Thank you.

Mr. MULKEY. The only question that I have is your reaction to the Colorado River Tribes' proposal.

Mr. WALEMA. At this time, I cannot make any statement as to whether we support or we do not support, but if this is going to save dollars for the Indian Health Services, then this proposal that was submitted would be backed by the Hualapai Tribe.

Mr. TAYLOR. I wanted to make an observation that I think we will be calling some of the Indian Health Service witnesses back. We have a few questions; among others, this blood standard, and questions that will go to percentage reductions, program funds in comparison to percentage reductions, or decreases in money allocated to personnel at the central and area levels. This has been a consistent point, and I think when we complete our witness panel, we would like to have Dr. Exendine and the other witnesses come back.

Mr. MULKEY. Be ready, Joe.

Thank you very much.

A VOICE FROM THE AUDIENCE. The chairman was not able to be here today, and he has all the testimony.

Mr. MULKEY. Would you identify yourself, please?

STATEMENT OF GENINE SAVALA, HEALTH DIRECTOR, KAIBAB-PAIUTE TRIBE

Mrs. SAVALA. I am Mrs. Savala, the health department director of the Kaibab-Paiute Tribe; our chairman was not able to be here today. I am forwarding our testimony to you at your office. I have a few notes, but I do not have a copy.

Hon. Senator DeConcini, members of the hearing panel, the Kaibab-Paiute Tribe through the years have received limited services from IHS. For the last 5 years, there has been no increase in funding of the contract of tribal health care. Despite the fiscal and funding limitations, tribal health care services have expanded to alleviate many problems of illnesses on the reservation, and an IHS clinic provides regular treatment for diabetic conditions, dental care, and eye care for all tribal members.

[Subsequent to the hearing, the following information was received:]

This expansion of health services has been restricted by geographical boundaries.

This statement refers to the Southern Paiutes of Southern Nevada and the Southern Paiutes of Utah, whose inter marriages have caused much hardship and heartaches on the southern Paiute reservations.

1. Because of the Southern Paiutes of Utah having been terminated and living on other reservations, have been restored.
2. Kaibab-Paiutes being married and living in the areas of So. Nevada and Southern Utah.

The U.S. Government Memorandum dated: November 22, 1978 states that IHS will authorize or deny payment depending on the individuals place of actual residence.

But going by the individual tribal rolls of the Southern Paiutes, this places a tribal member, who does not belong to that particular group of Paiutes in a hardship position, even though they may be blood relatives.

We would like to ask that an amendment be made to this, and that a Kaibab-Paiute living in Southern Nevada or Southern Utah be made eligible as a tribal member to receive health services.

This expansion has been restricted by many geographical difficulties. No. 1, no emergency medical care on the reservation because these services are 1 to 1½ hours in responding time to wait. No. 2, ambulance services are 45 miles away with 1 hour responding time. The nearest IHS hospital is 504 miles away, the Phoenix Indian Medical Center being 750 miles round trip. Public Health nursing is not available to tribal members because of the great distances the nursing units must travel. These distances have added to the cost of providing services to the people of the Kaibab-Paiute Tribe. The tribe, as a member of the great Paiute Nation, has suffered under these geographical and fiscal limitations.

While attempting to provide and maintain adequate health services to the Kaibab-Paiute Tribe with the 20-percent reduction, the Kaibab-Paiute Tribe has been placed in a no-win situation. Any further reduction in our operation of the Kaibab-Paiute health program will be extremely detrimental to the health and well-being of the Kaibab-Paiute people, as there are no medical services available to tribal members at the present time. The only immediate care available to the elderly is through the reservation.

In addition, the reduction of the staff of CHR's—in order to meet the reduction of the CHR budget—will only add to the unemployment statistics of the reservation. Any reduction to the workweek of the CHR program will decrease the purchasing capabilities of those individuals employed by the program and drastically reduce the health services on the reservation.

In all sincerity, the Kaibab-Paiute Tribal Council asks that Hon. Senator DeConcini and Hon. Senator William S. Cohen give their consideration to and honor the contents of this testimony. The Kaibab-Paiute Tribal Council asks that the CHR funding be restored to its original level and all other health services be restored to its original funding levels also in order to provide the health services presently needed on the reservation.

The Kaibab-Paiute Tribal Council requests the opportunity to reorganize the health planning. The Kaibab-Paiute Tribal Council for improved health service has taken several years to organize, only to become useless through the reduction in funding. The greatest country on earth and the land of plenty should see to it that the original people of this country are properly cared for, that the Kaibab-Paiute have the health services they need.

The Kaibab-Paiute people's health services have been reduced to the bones, and you have now asked us to give you the marrow. The 20-percent reduction in funding for health service for the Kaibab-Paiute and other Indian people will not balance the national budget, but will only add to a much greater deficit overall.

Mr. MULKEY. Thank you very much for coming.

[Subsequent to the hearing the following correspondence was received:]

Kaibab-Paiute Tribe

(602) 643-5545

Tribal Affairs Building
FREDONIA, ARIZONA 86022

Senator Dennis DeConcini
U.S. Senate
Dirksen Building, Room 4104
Washington, D.C. 20510

The Honorable Dennis DeConcini,

The Kaibab-Paiute Tribe located in the northwest corner of the state of Arizona, is extremely concerned about the reduction in funding for health services. As you are probably unaware of the situation of the Kaibab-Paiute Tribe, I will outline our concerns.

Through the years the Kaibab-Paiute Tribe has been at the absolute minimum level of funding for all health services and programs. Presently the Kaibab-Paiute Tribe receives limited services from Indian Health Service (IHS). There has been no increase in the funding for contracted tribal health care over the past five years. Despite the fiscal limitations, tribal health care services have expanded to alleviate many of the past problems of illness on the reservation. Each month the Community Health Representative Program holds an Indian Health Service Clinic on the reservation. These clinics provide regular treatment for diabetic conditions, hypertension, dental and eye care for all tribal members. This expansion has been restricted by many geographic "difficulties":

- There are no Emergency Medical Services on the reservation because these services are one to one and-a-half hours esponding time away.
- Ambulance services are twenty-five miles away with a one hour responding time.
- The nearest Indian Health Service Unit is 504 miles away (round trip) and the Phoenix Indian Medical Center is 750 miles away (round trip).
- Public Health Nursing is not available to tribal members because of the great distance the nursing unit must travel.

For many years the non-existence of Public Health and Indian Health Service Facilities within Southern Utah, Southern Nevada and the Arizona Strip, where the Kaibab-Paiute Tribe is located, has added to the cost of providing services to the people of the Kaibab-Paiute Reservation. The Kaibab-Paiute Tribe, as a member of the Great Southern Paiute Nation, has suffered under these geographic and fiscal limitations while attempting to provide and maintain adequate health services for the Kaibab-Paiute People, with the present twenty percent reduction the Kaibab-Paiute Tribe has been placed in a no win situation.

Any further reductions in or the elimination of the Community Health Representative Program will be extrememly detrimental to the health and well-being of the Kaibab-Paiute People, as there is no Medicaide available to the tribal membersand only Medicare is available to the elderly people of the reservation. In addition, to reduce the staff of the Kaibab-Paiute Community Health Representative Program in order to meet the reduction of the Community Health Representative Budget will only add to the unemployment statistic on the reservation. Any reduction to the work week of the Community Health Representatives will decrease the purchasing capability of those individuals employed by the program and drastically reduce the health services on the reservation.

In all sincerity the Kaibab-Paiute Tribal Council requests that the Honorable Dennis DeConcini give his foremost consideration to and honor the contents of this statement. The Kaibab-Paiute Tribal Council desires the Community Health Representative funding be restored to its original level and all other health services be restored to their original funding levels in order to provide the health services desperately needed on the reservation. The Kaibab-Paiute Tribal Council requests the opportunity to reorganize health planning; this planning by the Kaibab-Paiute Tribe for improved health services has taken several years only to become useless through the reduction in funding.

The greatest country on Earth and the Land of Plenty should see to it that the original people of this country are properly cared for; the Kaibab-Paiute People have cut the health services budget to the bone as you have asked and now you have asked us to give you the marrow. The twenty percent reduction in funding for health services for the Kaibab-Paiute People and other Indian People will not balance the National Budget but will only add to a much greater deficit for all Indian People in health care and services.

Sincerely,

Bill Tom
Bill Tom, Chairman
Kaibab-Paiute Tribal Council

Mr. Mulkey. Next we have the Navajo Tribal Council, Peter MacDonald, chairman: Ron Wood, director, Navajo Division of Health Improvement Service.

If you would like to tell her who you are and who your colleagues are, you may proceed.

STATEMENT OF RON C. WOOD, EXECUTIVE DIRECTOR, DIVISION OF HEALTH, NAVAJO TRIBE, ACCOMPANIED BY MARSHALL TOME, DIRECTOR, DIVISION OF COMMUNITY DEVELOPMENT; AND GIL ARVISU, WATER AND SANITATION DEPARTMENT

Mr. Wood. Good morning, Mr. Mulkey, Mr. Taylor, and Mr. Richtman. I am Ron C. Wood, executive director of the division of health for the Navajo Tribe. With me on my immediate right is Mr. Marshall Tome, division director for the division of community development. On my immediate right is Mr. Gil Arvisu, who works with water and sanitation of the Navajo Tribe and next to him is Mr. Aktar Zahman.

The pages I gave you consist of testimony from the Navajo Tribe and appended to that are some other pages of information and some graphs that graphically illustrate some of the points we are making in regard to workload and budget per capita figures. Also appended to the testimony is a report called the "Economic Recovery on the Navajo Reservation—A View From Window Rock." We are attaching this document, this testimony, because we feel very strongly that when we look at the budget cuts, we cannot look at the IHS and the health budgets alone. I think we have to look at the economic status of the Indian tribes and all the other programs that affect the Indian tribes.

In regard to the actual testimony, there are seven main points made, and I would like to briefly go through that and summarize and point out on the graphs attached some of the highlights.

Under the Reagan administration, the budget cuts are having a severe impact upon services that the Indian Health Service delivers directly and through contracts with Indian tribes or organizations. These budget cuts will eventually cause a decline in the health status of the American Indian people nationwide. I think it is important to note that fiscal year 1982, that budget marks the first time in the history of the Indian Health Service that their budget has been decreased.

The Indian Health Service experienced budget cuts from fiscal year 1981 to fiscal year 1982 and more are promised for fiscal year 1983. The budget cuts of 1981 to 1982 represented a decrease of $44 million. The President's budget for fiscal year 1983 proposes an additional cut of $33 million down to $613 million for all of Indian Health Service. This amount represents an approximate decrease of 11 percent over the fiscal year 1981 budget, and this does not take into account the effects of inflation, which has been running in excess of 15 percent per year for health services. So, in terms of real dollars and services, less can be purchased, and the decrease is on the order of 25 percent.

The No. 1 issue that we wish to bring to your attention is the issue of equity of funding for all Indian Health Service areas nationwide. The Navajo Area Indian Health Service provides 20 percent of all outpatient visits, 22 percent of all inpatient hospital days, and 35 percent of all obstetrical deliveries nationwide for the Indian Health Service, yet the Navajo Area Indian Health Service receives only 13 percent of the Indian Health Service budget. I would strongly recommend that Congress and the executive branch quickly review the allocation process that IHS uses for the fiscal year 1982 budget and start moving toward more equitable distribution of the limited resources nationwide among all Indian Health Service areas.

No. 2, is that the Indian Health Service's budget has been reduced, and there has been a tendency by the Indian Health Service to retain funds primarily for the hospital and clinic portion of their programs and to defund the preventive health programs such as community health nursing, community health representatives, and other community health services. We realize that the hospital and clinical services must be a priority, but preventive health services are important also. It is our opinion that the Indian Health Service tends to be overly facilities-oriented and physician-dominated at the expense of community health programs, community development, and preventive health-type programs.

Of special concern to the Navajo Nation is the fiscal year 1983 Reagan administration proposal to completely eliminate the CHR funding and program. If this occurs, the Navajo Nation will be left without any effective community and home health program. As you know, we would like to point out that the CHR programs are a lot more than just community health representatives, as such, that on the Navajo Reservation, we use part of the CHR allocation to operate an ambulance service. If it was defunded, it would leave the entire Navajo Reservation without an ambulance service. We also use CHR funds to fund additional programs, tuberculosis and venereal disease control, so the CHR programs are much more than just a community health representative. I would consider ambulance service as a basic social safety net service.

No. 3. In regard to budget cutting, the Indian Health Service has had a tendency to reduce tribal health programs to a greater extent than that of the Indian Health Service programs. I do not think the tribal programs should have to take a disproportionate share of the cuts. The IHS contract care funds have not been increased, and many non-IHS service providers are operating on inadequate contract care funds, and the situation is becoming more and more critical in terms of need.

No. 4. In the above points, we have emphasized the need to preserve the preventive health of the IHS, and although we may criticize physician domination and facility orientation of the Indian Health Service, we are fully cognizant of the fact that without adequate facilities, the level of health care that our people will receive will be less than adequate.

In March 1980, the Indian Health Service, at the direction of the Congress, did develop and implement a list of priorities for future construction of health facilities nationwide. This is one of the primary reasons that facilities such as Chinle were funded, and though the Chinle Hospital nears completion, Congress has yet to make provision for staff housing. Next on the listing was a replacement facility at Crownpoint, N. Mex. According to that listing, the Crownpoint Hospital in Crownpoint, N. Mex., was rated as the most critically needed replacement hospital in the country, and in 1981, funds were appropriated for a replacement facility. Funds were approved for planning for $1.3 million. Those funds were withheld, and just recently during the past month, they were finally released, so $1.3 million has been released to plan a replacement facility for Crownpoint. However, no funds were appropriated for construction in fiscal year 1982, and the funds are missing in the budget for fiscal year 1983. We realize the budget cuts are severe, but the entire Eastern Navajo Nation area does not have access to an adequate hospital and we have proposed that funds be restored to start construction of that facility.

No. 5. I would like to comment, Senator DeConcini, on the critical need to obtain funding for the Chinle Hospital. A couple of points that we need to bring to the attention of the committee, however, and I am sure you gentlemen are quite aware of this and that is, the issue of housing has not been resolved yet. We are facing a situation where a new facility will be technically ready to go into operation by October of this year, but there is no housing there for staff, and in addition to that, the Office of Management and Budget has virtually halved the proposed staffing for the facility. So, we will have a nice new facility without any housing for staff, and with less than half the staff needed to operate the facility. I think this is a false economy, and we would appreciate your advocacy in getting this hospital fully operational, as soon as possible.

No. 6. In regard to block grants, the administration has proposed a series of block grants to the States, and conspicuously absent in the early discussion was the issue of Indian tribes. I think the administration considered Indian tribes as a local unit of government somewhere under the State government. Chairman MacDonald and other tribal chairmen across the nations were very quick to point out that we are not just another local government. We have a special relationship with the Federal Government, and we want to deal with the Government, directly from the tribal to the Federal Government level. Essentially, the Indian tribes were greatly concerned that they were excluded from the block grant programs because of their special, historical relationship with the Federal Government. What we recommend is that Congress and OMB reconsider the issue of Indian eligibility for block grants and include Indians in all future block grants proposed by the administration.

My final point is in regard to water and sanitation and that portion of the Indian Health Service budget. I think this portion of the budget has been tremendously successful in elevating the health status of the Indian people nationwide by disease reduction and by improving personal hygiene in the home. It is very discouraging to see that the President's proposed budget for 1983 does not include any funds for this portion of the budget. It is our hope this committee and Congress will be receptive to restoration of funding for critical budget items such as water and sanitation.

Tied into the issue of water and sanitation is the Indian housing program where houses are built and IHS contributes the funds for the water and the sanitation. If you do not have one, you cannot obtain the other. It is very critical that those two programs be coordinated.

To summarize, I would like to say that the fiscal year 1982 budget cuts are severe and will have detrimental effects on the health services being provided. The proposed fiscal year 1983 budget, if approved, would eliminate major programs such as preventive health and facility construction, and for all practical purposes, the social safety net for Indian people would be wiped out. I sincerely hope that this committee assists the Indian tribes in having these funds restored to the Indian Health Service budget, and I would like to commend the committee for holding these hearings at this very critical point in the budget process. Thank you for this opportunity.

I would like to point out to you that you have some graphs appended to the report that will very graphically demonstrate the inequities of funding of the Indian Health Service nationwide. On just about all indicators, you will find that the Navajo and Phoenix area IHS carry some of the highest workloads in the country and, on a per capita basis, are receiving the lowest dollar amounts.

The health care amendments of 2 years ago asked IHS to start achieving equity. The joint conference committee has asked IHS to start achieving equity, and it is my concern that IHS is not moving rapidly enough toward equity. When budget cuts are given, a lot of these cuts are across the board, and those who have been poor in the past are even poorer now. If we have to reduce the budget and the administration is approving across-the-board cuts, I think the committees could help the Indian tribes tremendously by monitoring that budget-cutting process to make sure the budget cuts are selective and to achieve equity of funding among all Indian tribes.

That concludes our testimony. Are there any questions?

Mr. MULKEY. Do you know if the tribe has a position on the Colorado River Tribes' proposal?

Mr. WOOD. Sitting in the audience earlier, I anticipated you asking that question, and I did scribble a quick note. Although the Navajo Tribe has not had a chance to analyze all the ramifications of such a policy, my initial reaction is that since the IHS resources are so limited that they should be for those Indians who have the greatest need and have the least amount of alternative resources, and since Indians of a fuller blood quantum tend to have the greater need, particularly on the reservations, I would say we would be supportive of blood quantum eligibility in order to promote better health services for these Indians in greatest need.

Mr. MULKEY. Do you have any idea of numbers of people that might be eliminated or have to pay if such a proposal were enacted in the Navajo area?

Mr. WOOD. As I say, that is a very recent topic for the Navajo Tribe. I would estimate the effect would be negligible because most of the Navajos are of full, or at least, half or quarter of a blood quantum and would not be affected by that. I think there are other tribes that are more integrated into the dominant society that would be much more affected and for whom it would be a much more significant factor.

Mr. RICHTMAN. I have a question on the equity in funding, that issue that you raised. What kind of considerations should be made in trying to establish more equitable funding between, say, percentages of outpatient visits and percentages of the population? Are there other considerations that need to be taken into account?

Mr. WOOD. I think there are very definitely other considerations that should be taken into account. The Indian Health Service has a workload methodology called the resources requirement methodology. That methodology determines the workload and the funding is based on that. One of the crucial factors, I think, that is missing in that methodology is the amount of other resources that an Indian tribal group would have, and the *Rincon* court decision in California—you know California Indians were found to be at the lowest level of the funding for the Indian Health Service, but what has not been taken into account is that California has one of the best State health programs in the Nation, and anytime that you are starting to look at equity of funding, I think you should look into or take into account the alternative resources that Indian tribes may have.

Mr. RICHTMAN. Including tribal resources?

Mr. WOOD. I think tribal resources are going to have to be looked at also.

Mr. RICHTMAN. What about figures on the incidence of different illnesses?

Mr. WOOD. I think that should also be looked at, because for reservation Indians, who live without water or electricity, there is also going to be a greater incidence of environmental-related diseases, as compared to urban Indians who would have those facilities. I think a lot has to be done in terms of looking at all of the factors that should be included in equity of funding. I do not think the current recommendations do that. It does not look at State resources that are available. In the State of Arizona there have been very little State health resources available to Indian tribes.

Mr. RICHTMAN. Does the current approach take into account the general costs of medical care? For example, in Alaska, as compared to Arizona?

Mr. WOOD. I do not know if the methodology takes into account the regional cost factor. I would think that should be a consideration in equity of funding since Alaska is a high-cost area, and that would represent an inequity that would have to be taken into account by any methodology.

Mr. MULKEY. Thank you very much.

The material you have submitted will be made a part of the record at this point.

[The material follows. Testimony resumes on p. 419.]

TESTIMONY FOR
IHS BUDGET OVERSIGHT HEARINGS

February 15, 1982
Phoenix, Arizona

Good morning, Senator DeConcini and staff members, I am Ron C. Wood, Executive Director of the Division of Health for the Navajo Tribe. On behalf of the Navajo Tribe, the following comments are presented on the effects of the budget cuts on Indian Health Service programs and the delivery of health services to the Navajo people.

Health services have traditionally been provided to the Indian tribes of America under the authority of the Snyder Act of 1923, and the Indian Health Care Improvement Act of 1976 (P.L. 94-437). Under the auspices of the Indian Health Care Improvement Act, we had great expectations that the federal government was going to provide the necessary health resources to Indian tribes and Alaskan Natives in order to upgrade the level of health status to that of the general U.S. populace. Unfortunately, funds under the Act have never been appropriated at the authorized levels. In fact, less than half of what was proposed has been funded. Before the Reagan Administration, sufficient resources were never made available to accomplish the stated goals of Congress. Now, under the Reagan Administration the budget cuts are having a severe impact upon services that the Indian Health Service delivers directly and through contracts with Indian Tribes or organizations. These budget cuts will cause a decline in the health status of the Navajo People and all Indian people nationwide. The hope and promise of achieving parity in health with the rest of United States is turning into another broken dream. The FY 1982 budget marks the first time in the history of the Indian Health Service that their budget has been decreased.

Indian Health Service experienced budget cuts from FY 1981 to FY 1982 and more are promised for FY 1983. The budget cuts represented a decrease from 1981 to 1982 of $44,381,000. The President's budget for FY 1983 proposes an additional cut of $33,517,000 down to $613,280,000 for all of Indian Health Service. This amount represents an approximate decrease of 11% over the FY 1981 budget and this does not take into account the effects of inflation, which has been running in excess of 15% per year in health and which will result in an even greater decrease in terms of real dollars and services that can be purchased.

Today I propose the following specific recommendations which may give guidance to Congress and the Executive branch of government in providing adequate health care services to the Indian people:

(1) The issue of equity of funding of all Indian Health Service Areas surfaced as a problem in the last couple of years after the Rincon court decision. The Navajo Area Indian Health Service has cut its services to the absolute minimum across the board and cannot absorb any more budget cuts without actually closing down hospitals or clinics and/or denying vital health services. I want to point out to you that the Navajo Area Indian Health Service provides 20% of all outpatient visits, 22% of all inpatient hospital days, and 35% of all obstetrical deliveries nationwide for the Indian Health Service. However, the Navajo Area Indian Health Service receives only 13% of the Indian Health Service budget. An additional example regards alcoholism, which is the leading health problem on the Navajo Reservation. The Navajo population represents 17.5% of the national Indian population but the Navajo Area receives only 9.5% of the budget for alcoholism treatment services. Inequities of this magnitude must be corrected. I strongly recommend that Congress and the Executive Branch quickly review the allocation process for the FY 1982 budget, which is being finalized this month by IHS, to insure a more equitable distribution of resources nationwide among all IHS Areas.

(2) As the Indian Health Service's budget has been cut, there has been a tendency by the Indian Health Service to retain funds primarily for the hospital and clinic portion of their programs and to defund the preventive health programs such as Community Health Nursing, Community Health Representatives, and other community health services. Hospital and clinical services must be a priority but preventive health services are important also. Some of the primary determinants of health status are environmental factors and this is why it is critical that preventive health services do not suffer unduly in the budget cutting process. The Indian Health Service tends to be overly facilities oriented and physician dominated at the expense of community health promotion and preventive health-type programs. I would urge this Committee to monitor the Indian Health Service budget to insure that the preventive health programs are not cut disproportionately, as this is only a short term economy which will result in long term increases in illness of Indian people nationwide.

Of special concern to the Navajo Nation is the FY 1983 Reagan Administration proposal to completely eliminate the Community Health Representative (CHR) funding and program. If this occurs the Navajo Nation will be left without any effective community and home health program. In addition, the extensive Emergency Medical Services program which is funded under the CHR program will be completely wiped out, leaving a geographic area the size of West Virginia without any ambulance service. This must not be allowed to happen for lives will be needlessly lost. I strongly urge that the recommended cut of the CHR program not take place.

(3) As the current budget cutting is applied to the Indian Health Service, there is a tendency by the Indian Health Service to reduce funds used to operate tribal health programs to a greater extent than its funds are reduced. There has also been a tendency by some Indian Health Service Areas to take disproportionate cuts from the service delivery programs and not apply similar cuts to administrative functions. We believe that a principle of equity should be mandated by Congress to treat Federal and Tribal health programs equally and with parity. Of critical importance is the need for Congress to provide increased contract care funds which fund emergent care and non-Indian Health Service providers. Tribal health programs should not receive a greater share of reductions and service delivery programs should be maintained to the maximum extent possible.

Tribal participation in the health care system is vital and within the mandate of the Indian Self-Determination Act (P.L. 93-638). However, in our opinion, the Act has not been implemented to any significant extent within the Indian Health Service. Until this occurs, it is premature for the Indian Health Service to withdraw or decrease the amount of tribal health management development funds that have been provided to Indian tribes.

(4) In the above points I emphasized the need to preserve the preventive health components of Indian Health Service. We may criticize physician domination and facility orientation of the Indian Health Service, but we are fully cognizant of the fact that without adequate facilities the level of health care that our people will receive will be less than adequate.

In March of 1980, the Indian Health Service, at the direction of the Congress, implemented the first objective methodology for prioritizing future construction of health facilities in the nation. A listing was developed for all Indian Health Service facilities based upon availability and need. This facilities priority construction listing was very much needed and long overdue and I would like to commend the Congress and Indian Health Service in developing this listing. In the past, Congress has utilized this list to fund IHS hospitals and clinics. In regards to the Navajo Reservation, the Crownpoint Hospital in Crownpoint, New Mexico, was rated as the most critically needed replacement hospital in the nation and funds were appropriated in FY 1981 to plan for a replacement facility. The Reagan Administration attempted to halt funding for this project but these planning funds recently have been released. However, no funds were appropriated for Phase I construction in FY 1982 and the Reagan Administration has not recommended any funds for construction in FY 1983. We very much need a new facility in Crownpoint. I urge this Committee to insure that this facility priority listing is adhered to and that those Indian health facilities nationwide that are most in need of construction or replacement receive necessary funds.

(5) The Chinle hospital nears completion but Congress has yet to make provision for essential staff housing. Since no alternative housing is available within commuting distance it will be impossible to staff the inpatient component on any but the most limited basis until housing is available. Unless Congress intends to allow this brand new hospital to sit largely vacant for years, it should provide for housing in the FY 1982 supplemental appropriations process. The same identical problem exists for the Inscription House Clinic which is to be finished in 1983. That clinic is located in one of the most isolated areas of the United States and without staff housing it too may sit vacant.

To make matters worse, recently OMB has virtually halved the already minimal proposed staffing for the 60 bed Chinle facility. Thus, even when housing is made available, staffing will be woefully inadequate to meet the health care needs this new hospital was designed to serve. We strongly urge that the staffing ceiling be raised to a level that will make the hospital an operational one.

(6) This past year the Reagan administration proposed a series of block grants to the States. Recognizing the special historical Federal-Tribal relationship, Indian Tribes nationwide were greatly concerned that they were completely excluded from the block grant programs. After an extensive public relations campaign, the language was changed to make Tribes eligible for the block grant programs administered primarily by the Department of Health and Human Services. The Department was responsive to having Indian tribes be eligible for these grants and to maintain the special Federal-Tribal relationship. However, the Office of Management and Budget recommended against Indian eligibility. The promulgated rules and regulations that were issued by the Secretary of Health and Human Services for all practical purposes eliminated Indian participation in the block grant programs by stipulating that an Indian tribe was only eligible if it had previously received direct categorical funding from the Secretary.

The Federal Government has a special trust relationship with the Indian tribes of the country as delineated in the Constitution of the United States. It is my sincere hope that Congress and OMB will reconsider the issue of Indian eligibility for block grants already passed and for inclusion in any future block grant programs proposed by the Administration.

(7) The Water and Sanitation portion of the Indian Health Service budget has been tremendously successful in elevating the health status of the Indian people nationwide by disease reduction and improving personal hygiene in the home. This has been achieved by providing water and sanitation facilities to Indian families. It is very discouraging to see that the President's proposed FY 1983 budget does not include any funds for this portion of the IHS budget. It is our hope that this Committee and Congress will be receptive to restoration of funding for this extremely critical budget item. The IHS sanitation facilities construction program on the Navajo Reservation is coordinated with various Federal Indian Housing programs. If the budget reductions are implemented, it would have a serious impact on 1881 housing units which are presently under design or construction at 79 different locations.

In addition, 700-800 homes would not be served, 500 units which have been proposed in the HUD allocation would be cancelled or severly reduced and 200-300 other homes would be denied water and sewer services. Furthermore, the recognized need exists on the Navajo Reservation to provide basic water and sewer facilities to 10.000 existing homes. To us these basic services are of vital importance to insure a healthy home environment for we are located in one of the most rural, isolated and economically depressed areas of the United States.

This concludes the testimony of the Navajo Tribe. To summarize, I would like to state that historically the health resources available to the Indian people and Alaskan Natives have been far below those of the rest of the American people. With the passage of the Indian Health Care Improvement Act of 1976 a hope was provided by Congress that the health status of the Indian people would be raised and improved. With the budget cuts of FY 1982 we are witnessing a reversal of that trend. The FY 1982 cuts are severe and will have a detrimental effect on the health services being provided. The proposed FY 1983 Administration budget, if approved, would eliminate major tribal programs in preventive health and facility construction. For all practical purposes, the "social safety net" for Indian people would be wiped out. As other Federal funds continue to dry up, the need for an adequate health care system on the Indian reservations becomes even more acute. To further cut or defund these programs is unthinkable if there is any truth in the commitments that the federal government made to Indian Tribes in exchange for their lands and recognition of their special status in the Constitution of the United States of America.

I sincerely hope that this Committee can assist the Indian Tribes in having funds restored to the Indian Health Service budget.

Thank you for this opportunity.

DIRECT WORKLOAD FOR IHS AREAS AND ALLOCATED FUNDS
FY 81

	Direct Days	Direct OPV	Composite Days	Total Direct Budget* (Millions)	Cost Per Composited Days
Tucson	7425	52964	16252	5.225	321
Aberdeen	51257	383486	115171	21.273	185
Bemidji	5981	98724	22435	12.431	554
Albuquerque	30188	262596	73954	17.583	238
Alaska	72890	295776	122186	54.652	447
Billings	13248	270781	58378	11.398	195
Oklahoma	61506	620097	164856	36.006	218
USET	10612	89026	25449	7.406	291
Phoenix	89654	425113	160506	32.196	201
Portland	------	188411	31402	6.446	205
Navajo	92890	632505	198308	37.389	189
Total	435651	3319479	988897	242.005	245

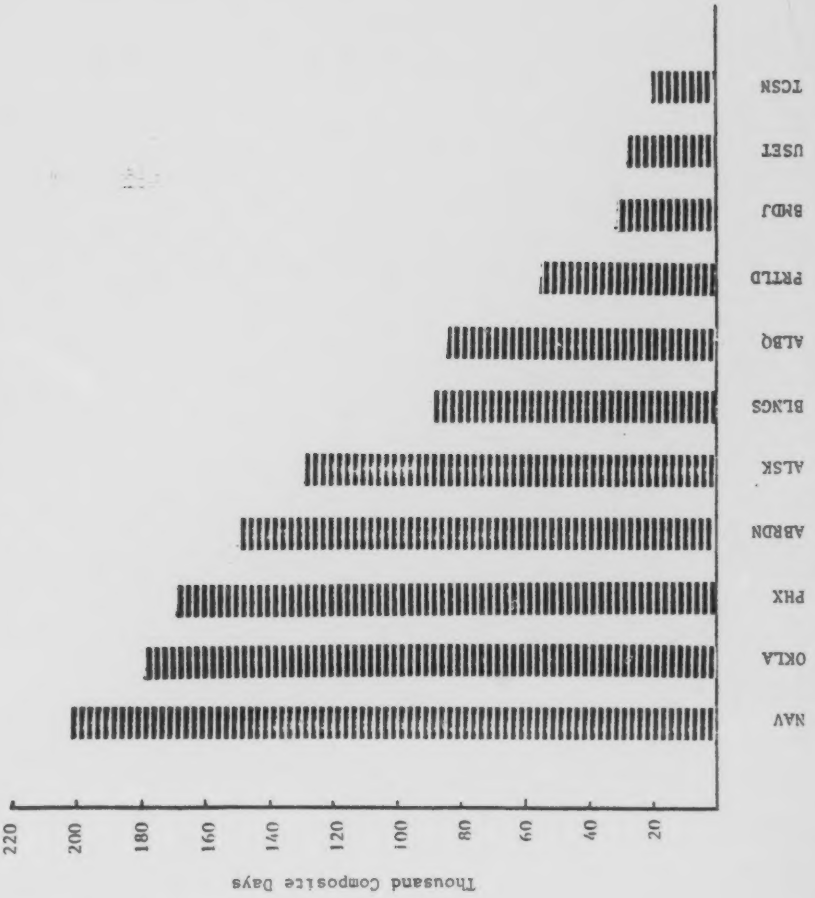
Source: 202 Data System and APC Report 1A
Note: *Allocation for Clinics and Hospitals, 2/81

Contract and Direct Workload
for IHS Areas and Allocated Funds, FY 81

	(1) Direct Days	(2) Contract Days	(3) Direct OPV	(4) Contract OPV	(5) Composite Days (1+2)+(3+4/6)	(6) Total Budget* (Millions)	(7) Cost Per Composite Day
Tucson	7425	3493	52964	3695	20,361	7.769	382
Aberdeen	51257	33934	383486	9514	150,691	32.653	216
Bemidji	5981	7672	98724	12758	32,233	16.312	506
Albuquerque	30188	9167	262596	5619	84,058	25.669	305
Alaska	72890	4523	295776	11417	128,612	65.168	506
Billings	13248	24893	270781	36161	89,298	24.867	278
Oklahoma	61506	13673	620097	4464	179,272	44.695	249
USET	10612	2964	89026	2545	28,838	11.306	392
Phoenix	89654	8203	425113	5466	169,620	43.024	254
Portland	--------	20068	188411	18079	54,483	20.616	378
Navajo	92890	3665	632505	1300	202,189	47.040	233
Total	435651	132255	3319479	111018	1,139,656	339.119	298

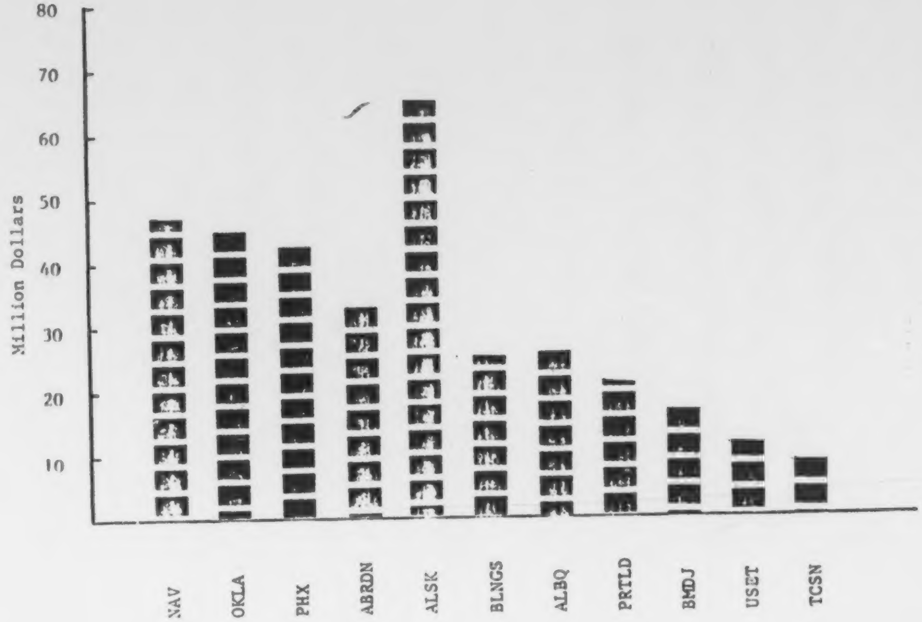
* Allocation for Hospitals and Clinics and Contract Health. 2/81

Sources: Workload Data from Contract Health 3G Report, 202 Data System and APC Report 1A, 2/82

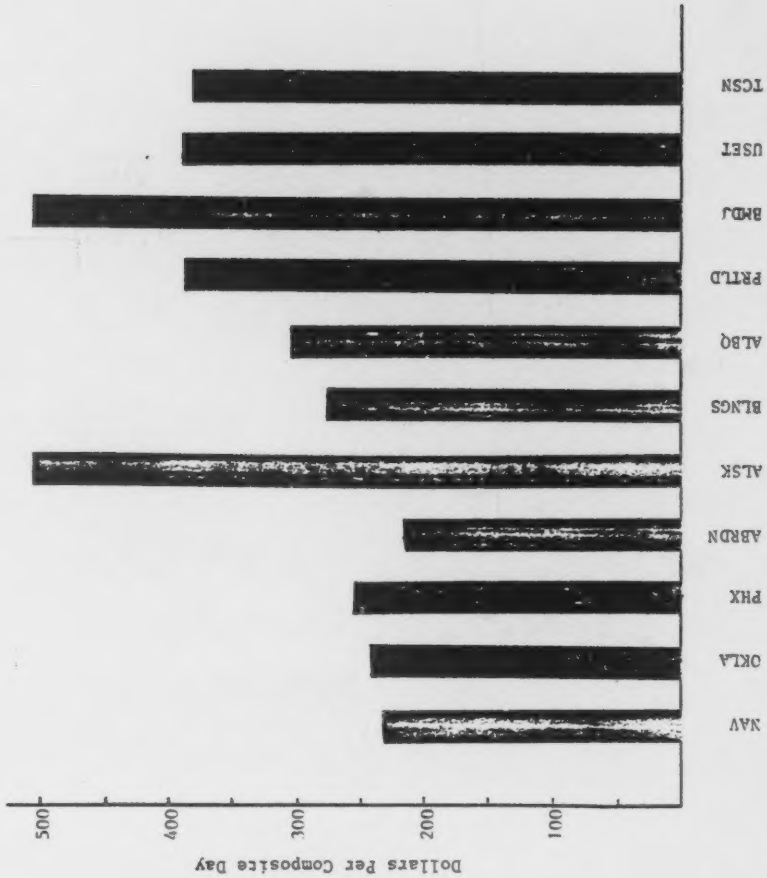


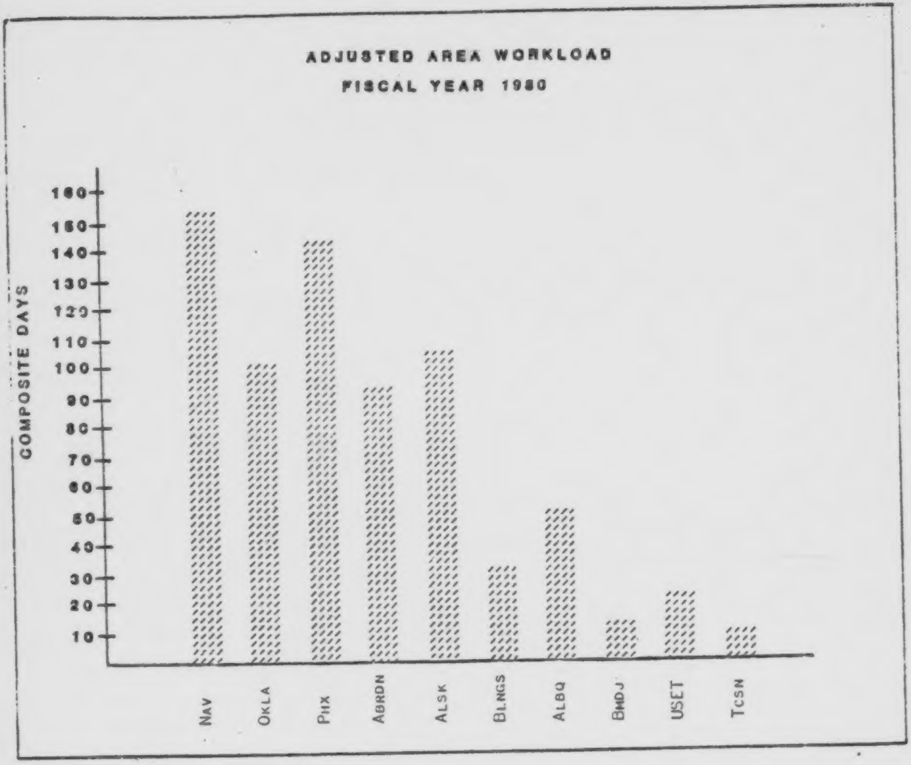
WORKLOAD BY AREA, FY 81
(Composite Days)

HEALTH CARE BUDGET BY AREAS, FY 81
(Hospitals & Clinics & Contract)

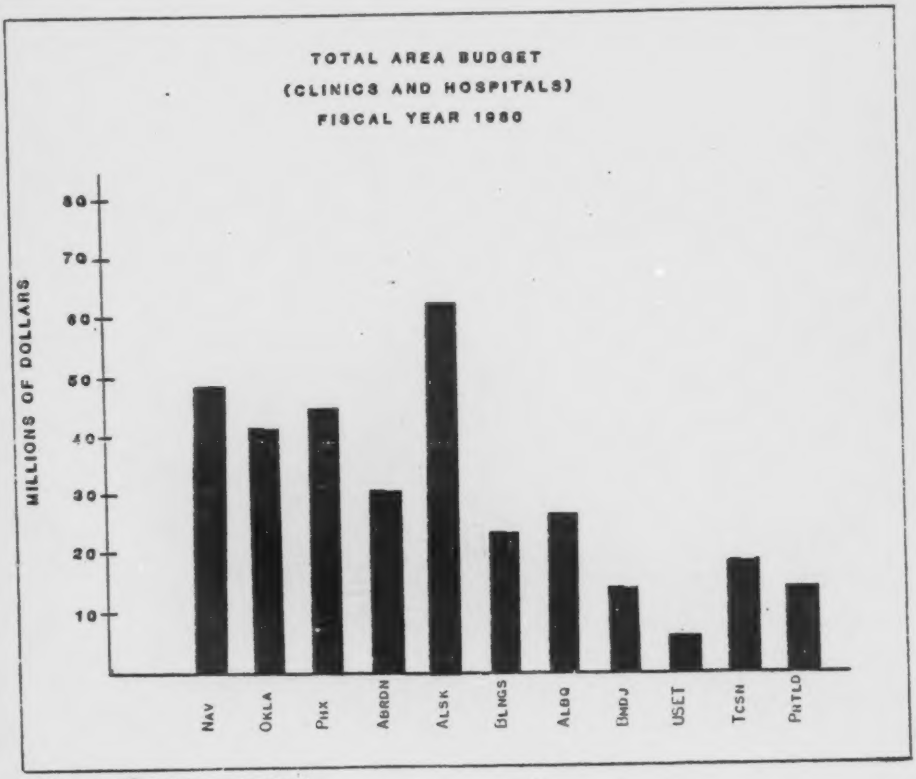


COST PER ADJUSTED PATIENT DAY
FY 81 (Dollars)

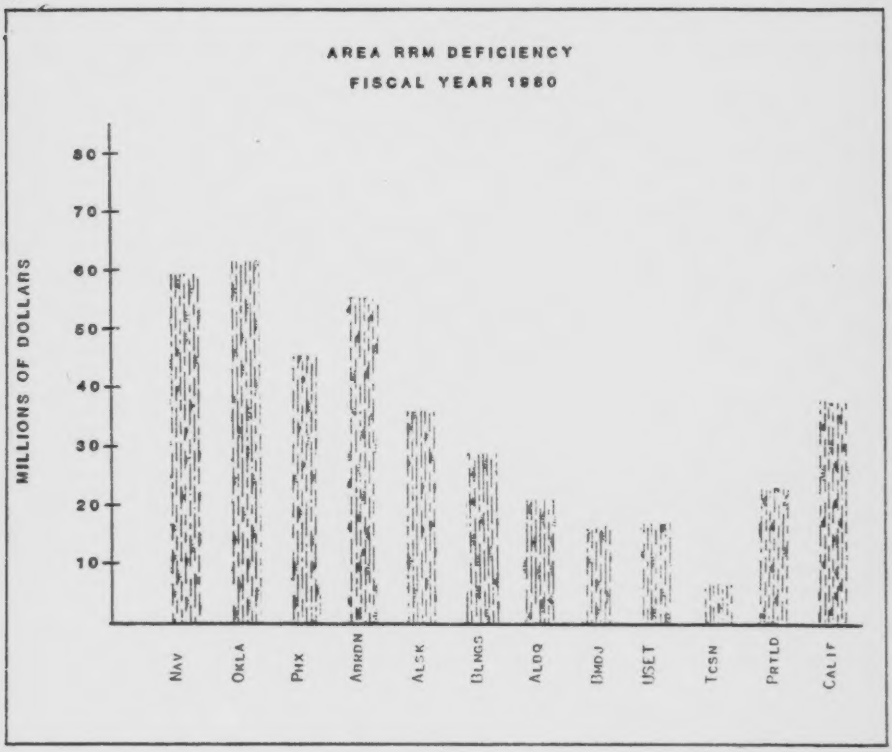




ADJUSTED AREA WORKLOAD
FISCAL YEAR 1980



TOTAL AREA BUDGET
(CLINICS AND HOSPITALS)
FISCAL YEAR 1980


AREA RRM DEFICIENCY
FISCAL YEAR 1980
MILLIONS OF DOLLARS
80
70
60
50
40
30
20
10
NAV
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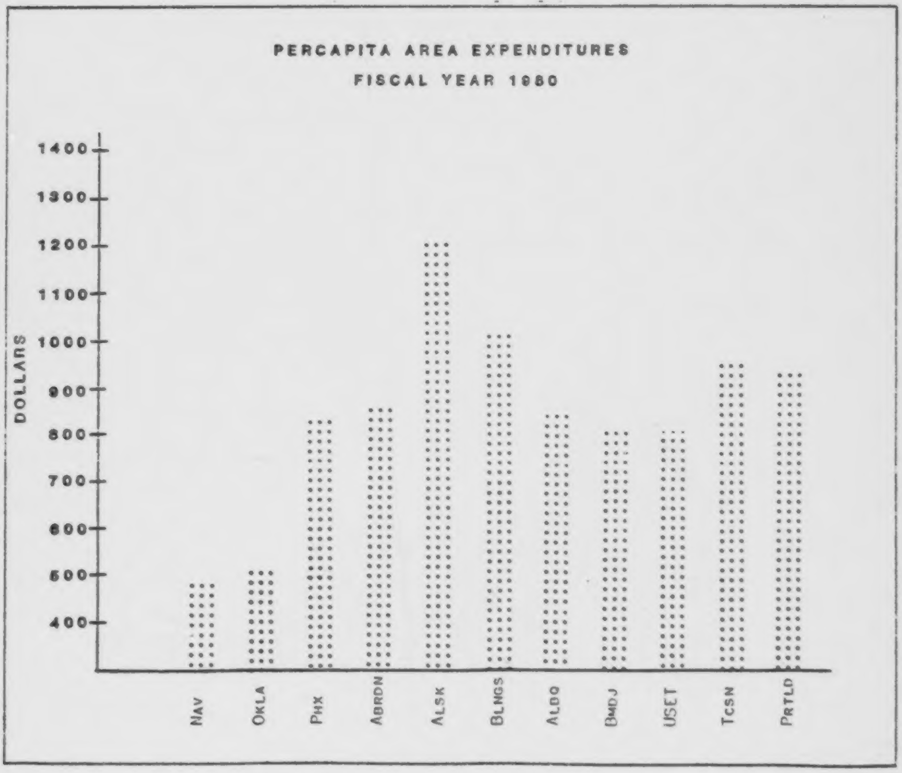
PERCAPITA AREA EXPENDITURES
FISCAL YEAR 1980
DOLLARS
1400
1300
1200
1100
1000
900
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700
600
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400
NAV
OKLA
PHX
ABRDN
ALSK
BLNGS
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BMDJ
USET
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PRTLD

Mr. MULKEY. Next is the Papago Tribal Council, Max H. Norris, chairman.

Mr. Chairman, if you would like to identify your colleagues, you may proceed.

STATEMENT OF MAX H. NORRIS, CHAIRMAN, PAPAGO TRIBAL COUNCIL, ACCOMPANIED BY MARY ORTEGA AND RALPH ANTONE, TRIBAL HEALTH STAFF

Mr. NORRIS. Good afternoon, Senator DeConcini and members of the committee. On my right is Mary Ortega and Ralph Antone, both of the executive health staff. My name is Max Norris. I am the chairman of the Papago Tribe of Arizona.

The Papago Reservation lies in the southwestermost area of the State of Arizona and covers a land area of some 3 million acres approximately the size of the State of Connecticut. We have a population of approximately 17,000 members scattered across 72 isolated villages, much of the area lacking paved roads and having no water or power supply. The major source of communication throughout the reservation is by radio, and very few telephone systems exist.

My testimony will concentrate on two major areas, on the impact of the Federal budget reductions that directly affect the Indian Health Service and those that impact directly on the tribal health delivery system. I would also like to add that by the most recent identification of our people, communities and the tribal council, health care has been set as the No. 1 priority and concern.

At the present rate of the Federal budget reductions the many strides we have made in bringing under control the great number of medical problems afflicting our people will again begin to rise to epidemic levels and finally a rise in our death rate will prevail. These budget cuts are being imposed on a segment of Americans that have the lowest income level in the United States, the least access to all health services and are the most in need of medical care.

The Papago people in these times are being asked to do with what they have, yet the treatment and care they have been receiving was never provided at a level to meet the total need and has never been comparable to that of the general public.

Since the start of the Papago community health representatives program in November of 1968, acting as the liaison between available health care and the lack of access were brought ever so close in; No. 1, provision of better utilization of health services by coordination and communication between the individual community members and the health resources; and No. 2, being the provision of health information and instruction of individual and families to assist in the elimination or alleviation of health problems. These are the stated objectives of the community health representatives program since its inception. That is, to meet the major goal of establishing and maintaining the community health representatives program for the improvement of health care and health services to Indian residents of the Papago Reservation.

It is through this major effort that we stand before you today and can reflect on the alleviation of deaths from diarrhea and the community awareness of combating both physical and environmental hazards and disease. We need to continue our efforts if we are to ever reach that level equivalent to that of the general public.

The community health representatives generalist, just by virtue of their existence, have brought about an enormous change in the many superstitions held by the Papago people about the benefit of western medicine. Our totally isolated areas have not been so isolated because of the community health representatives routine visits and their major role as educators and first responders to meet the health needs of our reservation.

Each community health representative averages approximately 1,500 contacts per year, which includes home visits, screening, followup by physician's referral, severity of illnesses, and dispensing over-the-counter medications as well as community education and patient transportation.

Due to budget cuts no services for a newly initiated safety program will be provided, yet this component was in great demand from the start of the program, and to do quality home visits, the community health representatives will cut down routine home visits and will almost eliminate any preventive care. Due to the inability to spread out a patient's clinic visits because of the cut in transportation funding, specialty clinics will experience extreme patient-waiting time increases and unusually large clinic patient-load.

The community health representative specialists' positions encompass: Mental health, elderly, nutrition, alcoholism, environmental health, and disease control services. Every one of these tribal health programs have been drastically affected by the budget reductions, which has resulted in having to decrease the total program operation. The bottom line effect of less funding is that the elderly, the young, and the chronically ill will be forced to do without the services and programs previously available to them.

All of these reductions come in light of the fact that 50 percent of the Papago people are diabetic, and we now have 17 dialysis patients with an expected increase of 7 new patients per year. The Indian Health Service budget reductions have placed us in a very agonizing situation of only providing emergency care for life-threatening situations under contract care and treating patients incident by incident for medical needs, totally leaving unaddressed the prevention of our medical needs. We have now occurring at the service unit level major cutbacks in staffing, supplies, and programs while at the same time an increasing demand and need for medical services.

It is our recommendation that any reductions in budget should be applied at the administrative level at all costs first, before beginning to impact on the provision of direct health services. We would also recommend restoration of Indian Health Service funding to at least the fiscal year 1981 funding level. This would enable the Indian Health Service and tribe to, if nothing else, maintain the desperately needed health services. This would entail a replacement of a total 64 percent cut from fiscal year 1981 base for the Papago area. This is the percent that has been reduced, to date.

It is our firm belief that no additional budget reduction should or can be applied to the Indian Health Service appropriations. The Papago Tribe feels firmly that we must appeal to the Congress to not have the lives of our people suffer just to bring about the need for military superiority.

I would like to close by stating we have come a long way from being treated for our medical needs, which were brought upon us by contact with the non-Indian society. If we should lose in our battle to maintain our badly needed health care system, we will surely return to our previous inescapable fate.

Thank you for your time and any consideration you can render on behalf of the Papago people and our generations to come. Thank you again.

Mr. **Mulkey**. Thank you, Mr. Chairman.

Do you have any reaction to the Colorado River Tribes' proposal?

Mr. **Norris**. We have a constitution that we abide by, and my reaction will be left up to general council to make whatever decision when it comes to them for consideration.

Mr. **Mulkey**. I am just curious. Do you plan on having it brought to their attention, or how will it be brought to their attention, or will it?

Mr. **Norris**. It is brought to their attention as soon as the need comes to be. The need is the most important factor. Now there are many things that are needed and are before the tribal council.

Mr. **Mulkey**. I understand. I guess the concern that I have is that some action would be taken by the Congress, and we would like to get the reactions from the various tribes on their opinion of this proposal, and I just wanted to ask you.

Max, do you have anything?

Thank you very much.

The Salt River Indian Community, Herschel Andrews, president.

Would you like to identify your colleagues and then proceed?

STATEMENT OF HERSCHEL ANDREWS, PRESIDENT, SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY, ACCOMPANIED BY HAZEL THOMAS, DIRECTOR, HEALTH DEPARTMENT

Mr. **Andrews**. My name is Herschel Andrews, president of the Salt River Pima-Maricopa Indian Community, and I have with me, Ms. Hazel Thomas, who is the health department director.

Mr. Chairman, members of the committee, it is a pleasure to be invited to testify on the impact of the fiscal year 1982 budget reduction and Indian Health Service funded and operated programs. We are deeply concerned about the total budget cutbacks imposed on our health care system.

Our tribal health management and community health representative programs are faced with a 20-percent reduction. This places a serious impact on our tribal health program. We will be forced to cut back on services and on staff time in order to comply with the request. It will also place an additional financial burden on the tribe if we have to rely on our resources because we are already faced with other budget cuts through the Bureau of Indian Affairs.

Furthermore, we wish to inform you we are not only suffering these reductions, but the health education position, with an individual on commission corps assignment from Indian Health Service to the tribe is in jeopardy. The Phoenix area health office wants to exercise its authority to break the commission corps agreement and plans not to restore the remaining salary for that position to the tribe.

We follow with two recommendations. One recommendation is to request that the CHR program and tribal management moneys be restored to the fiscal year 1981 levels. These health programs provide services very vital to our people. Without the advocacy of these programs, our eligible Indian people will be further pushed aside and non-Indians will continue to receive full treatment instead.

We recommend that the Phoenix area health office honor its agreement with the Salt River Pima-Maricopa government concerning the commissioned officer assigned to the tribe through the commission corp assignment. This assignment has been very satisfactory and profitable for both the tribal health program and the individual assigned to the tribe.

Due to the reduction, medical care has been cut back by the Indian Health Service hospital and clinic. The following are no longer provided to our Indian people: Wheelchairs, prosthesis and crutches; over-the-counter drugs; limited eyeglasses; and limited ambulance service.

Our clinic is staffed by one full-time doctor, one nurse, one medical records clerk, one part-time pharmacist, and two doctor's assistants. The clinic treats 200 outpatients per week, 1,000 to 3,000 patients per year. Of the total patients seen at the Salt River Health Clinic, one-fourth of the patients were considered off reservation or were less than one-fourth Indian.

Due to the reduction, two doctor assistants will no longer be available. This will add a greater load to the already overloaded full-time physician. The Phoenix Medical Center is located 15 miles away, 30 miles round trip. This poses a problem because of the limited transportation available.

Our health clinic is in a refurbished army barracks by ROFEC standards, the facility was considered in need of replacement. In 1979 we ranked 10 to replace our medical facility. We no longer are on the list for facility construction. We were taken off the list because the tribe was penalized for taking the initiative in remodeling an old barracks and providing a larger facility for its clinic which IHS leases.

We are requesting that the Salt River Clinic be maintained at the level of a health center. Besides keeping the present staffing, we are requesting the following: Another full- or half-time physician or 2½ times physician's assistant and one full-time pharmacist.

In order to elevate our level of health center, we, the Salt River Pima-Maricopa Indian Tribe request a line item appropriation for replacement of our outpatient facility on the Salt River Reservation.

Regarding quantum of Indian blood we concur with the Colorado Indian Tribes recommendation. At this point we are in favor of, and in support of, such legislation to start with.

Regarding the Phoenix service unit area. There is little or no direct input sought from the tribal health departments or tribal governments when IHS puts our health care plan together. We feel that many problems and waste of dollars can be eliminated if this should occur.

We have two recommendations:

No. 1. We recommend no local IHS health plan and budget be written without obtaining input from tribal governments or tribal health authority; and

No. 2. We recommend a tribal health system agency be formed, composed of tribal health directors or tribal health government leaders to have the authority to review and approve the IHS health plans.

On behalf of the Salt River Pima-Maricopa Indian community, I implore you to take necessary and corrective action to restore funding so our Indian people may receive the best health care they are entitled to.

We are asking for your support and cooperation. We are happy to answer any questions you may have.

Mr. MULKEY. One of your recommendations was that the Phoenix area health office honor its agreement with the Salt River Pima-Maricopa community government concerning the commission officer assigned to the tribe. Could you explain a little bit about that?

Mr. ANDREWS. Yes. This agreement was signed between the Salt River Indian community and the Public Health in 1980, and it is my understanding that they have notified the community, just within the last 2 weeks, verbally informing the community that they would be transferred. There were three options that I understand was given to the community. One was to request the commission officer to be assigned back to Public Health. The other was if the commission officer wanted to be retained or wanted to stay with the community, that she would have to resign her position, and the Salt River Indian community would have to pick up her salary, and the last alternative was for her, if she wanted to stay in Public Health, she would have to transfer to the Phoenix Indian Medical Center.

Mr. MULKEY. So?

Mr. ANDREWS. I will have her talk to that.

Ms. THOMAS. If this occurs, if she should return to the Indian Health Service, there will be no salary left in that position because that has been used up, so, therefore, we would only have the position, but we will not have any salary to hire another health educator.

Mr. RICHTMAN. The issue that was raised; what exactly was the agreement initially? Did the terms of the agreement include a time that has expired, because you sounded, in your testimony, as if you honored an agreement that is still in place. Is it?

Ms. THOMAS. The agreement was just extended recently to September of fiscal year 1983.

Mr. MULKEY. Are they suggesting this be done before the end of the fiscal year?

Ms. THOMAS. Yes. March 1, in fact.

Mr. MULKEY. Thank you, very much.

The material you submitted will be made a part of the record at this point.

[The material follows. Testimony resumes on p. 425.]

TESTIMONY OF THE SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY, SUBMITTED BY HERSCHEL ANDREWS, PRESIDENT

SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY TODAY

The Salt River Indian Community lies adjacent and to the east of the City of Scottsdale. Arizona and a few miles to the east of the City of Phoenix, AZ. Its southerly neighbors, just across the flood plain of the Salt River, include both Mesa and Tempe. The northern boundary is shared with the Fort McDowell Indian Reservation, the City of Scottsdale, Maricopa County and Fountain Hills. The

52,000 acres of land extend approximately 6 to 9 miles in a north-south direction and approximately 14 miles in an east-west direction.

The reservation can be divided into three distinct zones. The western area consists of approximately 15,000 acres of irrigated land. This is the area with the largest population. The northwestern area is similar to the western zone, flat or gently sloping, but is non-irrigated area. The remainder consists of rolling desert, not of immediate value for farming or stock raising. Elevation decreases from the northeast to southwest from 2,800 to 1,200 feet above sea level.

The Salt River Indian Community has its own constitution which was adopted on November 23, 1980. According to the constitution, the governing body, known as the Salt River Pima-Maricopa Indian Community Council, consists of a President, Vice-President and seven councilmen. The body is elected by a popular vote of the Salt River Pima-Maricopa Indian Community. The President and Vice-President serve a term of four years; the councilmen also hold four year terms, however, the terms are staggered. The Tribal Council employs a Community Manager to direct the daily operations of the tribe. The tribal headquarters is located at Salt River.

There are approximately 3,081 Indian people living on the Salt River Pima-Maricopa Indian Reservation. The community is predominately made up of the Pima and Maricopa tribes.

The economy of the community is based primarily on agriculture. Approximately 15,000 acres of land are leased to farmers annually. Sand and gravel mining companies operating along the Salt River bottom provide some income for the tribal government and employment opportunity to a very small percent of community members. The tribal government employs approximately 250 individuals. However, most members must seek employment off the reservation.

CURRENT HEALTH SERVICES

Health services provided on the Salt River Pima-Maricopa Indian Reservation can best be described in two general categories. Those services directly provided by the Indian Health Services and the health service provided by the Salt River Tribal Health Department.

Indian Health Service

The Indian Health Service provides direct patient care in three areas: medical, dental and community health nursing. Medical services are provided on an outpatient basis. Primary health care is provided on a daily weekday basis from 8:00 to 4:30 p.m. In addition to generalized services, there are certain specialty clinics provided at the Salt River Health Clinic. Those include: Well Child, Mental and Gynocology clinics once a week; diabetic and prenatal twice a month and surgical clinic once a month. The clinic is staffed by a full time general practitioner, one Registered Nurse, and medical records clerk. In addition to these individuals the clinic is staffed part-time by a physicians assistant, nurse practitioner, and pharmacy practitioner.

Dental services are provided on the Salt River Reservation by the Indian Health Service. Services include generalized dental care which encompasses a wide area of dental procedures with the exception of orthodontic services. The Dental clinic is open each weekday from 8:00 to 4:30 p.m. All emergency dental care required beyond regular dental hours is provided at PIMC which furnishes a dentist on call 24 hours a day, seven days a week.

The Community Health Nursing Program available to the Salt River Community provides the services of two (2) full time Public Health Nurses and a nurse trainee. This staff of field nurses is maintained by the Public Health Service. The Nursing Division provides extended and follow-up care in disease prevention and health education.

Tribal Health Programs

The Salt River Indian Community offers health care to the Salt River Indian residents in three tribal health programs. These programs consist of a Tribal Health Management Grant; a Community Health Representative Program, and a Women, Infant and Child Nutritional Supplemental Program.

The Tribal Management Program is staffed by a health director, health planner, health educator and secretary. The Tribal Management Program, funded under P.L. 93–638, Self-Determination Act, is designed to analyze and initiate the operation of a tribal health department.

The Community Health Representatives Program under contract with the Indian Health Service is designed to provide community health support service and a comprehensive health education program to all residents of the Salt River Community. Areas of concern involve: School Health, Diabetes follow-up, Maternal/Child Health, Transportation and Health Surveillance of the Elderly. The Community Health Representative Program is staffed by a CHR Director and three (3) CHR personnel.

The Tribe also administers a Women, Infant and Child Supplemental Nutrition Program. The program is established to offer quality nutrition services which contribute to the improvement of nutritional status and overall health to residents of the Salt River Pima-Maricopa and Ft. McDowell Indian Reservations. The Women, Infant and Child Program is staffed by a Community Nutrition Worker, a clerk-typist and a part-time nutritionist.

EXISTING HEALTH FACILITY AND CONDITION

The temporary wooden structure (a military surplus building) consists of approximately 3400 gross sq. ft. of floor space containing: entrance, examining rooms, drug and supply storage space, patient waiting room, community health nursing, service unit administration, dental service, conference rooms, the C.H.O. Program, the W.I.C. Program and the Tribal Health Department Administration

Because of the many services provided within a minimum square feet, extreme overcrowding exists. The emergency room and the physician's office are being used as overflow exam rooms. The physician's office has been condensed into a supply closet space. Emergencies are squeezed between examinations in one of the overflow rooms. Offices are shared to over capacity. Hallways are utilized for storage and a receptionists' desk. Medical supplies, records and drugs are also stocked in a limited space.

Dental and medical clients share the undersized patient waiting room. There is no dental office. A receptionists' office and storage space are also needed for the dental area. The Health Department Administrative office wing has no separate exit. Staff must exit through the patient waiting room. If there were a fire, this could create further exit crowding. The heating and cooling systems are inadequate. Some sections remain cold in the winter and hot in the summer. Uneven floors cannot support needed equipment. Ceilings in both a storage room and the patients' waiting room leak considerably, causing a dangerous condition through wet floors and a sagging ceiling. The rain saturated ceiling in the waiting room indicates continued possible dangers for patients. All of these factors hinder effective, extended use of the facility.

In light of existing conditions the Salt River clinical staff continues to see a tremendous patient caseload each month.

The clinical staff will see approximately 13,000 patients in FY 1981 as compared to 10,000 last fiscal year. At this rate the staff sees over 50 patients each day. The continued increases in population on the Salt River Indian Reservation can only aggravate existing conditions.

Mr. Mulkey. The San Carlos Apache Tribal Council, Ned Anderson, chairman.

Mr. Anderson. I do not have a prepared statement.

Mr. Mulkey. Please, proceed.

STATEMENT OF NED ANDERSON, CHAIRMAN, SAN CARLOS APACHE TRIBAL COUNCIL

Mr. Anderson. Members of the panel: My name is Ned Anderson. I am tribal chairman of the San Carlos Apache Tribe and president of the Intertribal Council of Arizona. Except for one item at the end, the things I am going to say here will relate to concerns of my tribe, the San Carlos Apache Tribe.

I think it goes without saying, given the testimony that has been given today, that the impact of the proposed budget cuts in Indian country is going to be severe. This is the same over at San Carlos, my tribe. I can give you statistic after statistic as to how the reductions will affect me and my people, but I think I am going to just give a brief rundown as to that. Detailed information will be sent to you in due time; before the deadline at any rate.

It used to be that the Indian tribes would come before a committee like yours and ask for modern equipment, modern facilities. It is ironic, I think, that with the onset of the so-called New Federalism we are not making a plea to let us hold onto what we have insofar as funding is concerned, not only for IHS-related programs, but others as well.

To give you an idea as to what we are talking about, as far as my tribe is concerned, please bear in mind that there are 8,000 people who, just like yourselves, need adequate medical care. These people are centralized in two locations: One in the community of San Carlos, the other at Bylas. As far as land base, we have roughly 2 million acres. Of the 8,000 people, approximately 2,500 are over at Bylas. The rest are over at San Carlos.

San Carlos presently has an obsolete medical facility. The capacity is 36. Over at Bylas we do not have a structure as such, simply a trailer, which serves as a clinic, and not on a 24-hour basis. The hospital that I mentioned is only 20 years old. People were so lucky to say that they were at least on a priority list. Given the prospects now, it appears like there will not be any list. It is not going to hurt us because I do not think we were ever on any list.

Over at San Carlos we had approximately 92 positions in the past. If there are going to be any further cuts, this will mean dropping the positions to 50. We had approximately 92 positions before, when things were a little better off. I will show you what I mean after awhile, as to what I meant when I said things were a little better off. I was told by the service director that we were very lucky to have squeezed through fiscal year 1981. We had to reduce a lot of things, including inventory, autos, and the like.

We have a 15-bed unit for adults over at San Carlos. I am told that we are now down to two, primarily due to a shortage of nurses. I suppose the answer would not necessarily be the number of beds you can have for patients. Why? Because, first of all, you are going to have to have adequate space for the clinic. You are going to have to have the equipment which you can use to cope with the various diseases that afflict, not only our people, but other Indian peoples as well.

I was told also, that at the present pace, as far as deficit within our service unit is concerned, the projection for 1982 is only $539,699. If we have even a 10-percent cut over at this service unit at San Carlos, it would mean complete closure of the inpatient care division. I think you heard a statement by the chairman of the White Mountain Apache Tribe a little earlier to the effect that there is a proposal in the air that patients from San Carlos could be shipped to his service unit—which is the White Mountain Apache Service Unit—if there is a closure of our inpatient division at San Carlos. You heard him say that even now he cannot serve all his people. That speaks for itself, but I would like to add that I do not think my people would want to be shipped to that service unit. They want to be cared for where they are at San Carlos.

I mentioned some of the things that would happen, given the reductions. Let me just point out a few things here. As far as subsistence, we have requested $16,745, barely enough, yet given the reduction that would be brought down to a mere $2,820. Drugs: We requested $133,915. What I see here is a figure that says $19,500 for drugs. We used to get aspirins and house service. I guess we will end up with aspirins only, now. Medical supplies: We requested $64,927. This would be reduced to $13,000. These are just a few examples. I have a long list.

Mr. **MULKEY**. May I ask a question?

Mr. **ANDERSON**. Go ahead.

Mr. **MULKEY**. Are these reductions that you are giving for this year?

Mr. **ANDERSON**. For 1982.

Mr. **MULKEY**. Based on what?

Mr. **ANDERSON**. Given the 10-percent reduction.

Mr. **MULKEY**. OK. Go ahead.

Mr. **ANDERSON**. In the 11 months of operation last year, the actual working staff was about one-half of what was needed. The service unit had only 50.7 percent actual working staff; it was never adequately staffed.

It appears to me that people have a tendency to make what I call a priori assessment, particularly when they go to an Indian reservation like ours. In other words, they come and they take a look at the situation at the moment, never realizing what was before. To have an appreciation for what is happening here, I think we need to take a look at what had to take place.

You see our people were reluctant to accept modern medical treatment at first. There had to be a great deal of educating. It seems like we were successful as far as educating our people in that way. Just as they have become used to receiving such care, the carpet is being pulled from under them. You must remember what they were offered before was inadequate in terms of quantity and quality. As far as education is concerned, the community health representatives did a real good job.

If there is a proposal to the effect that that should be eliminated, we are strenuously opposed to that. Any further budget cuts would mean, over the long term, that there would be a drastic increase in the incidence of preventable diseases and increase the workload for already overworked hospital staff as well.

Must I remind the U.S. Government of their special relationship that is supposed to exist between it and the Indian tribes. Most of the legislators, if not all of them, are law-trained. Something like this should be fundamental to them. Why is it that we have to keep reminding you that there is such a relationship? If you have not been educated, then I think one of the basics that a legislator, especially at your level, that is supposed to be taken for granted is that you know some of the organic documents including the Trader Intercourse Act, the Northwest Ordinance Act, the U.S. Constitution, in which there is such a thing known as commerce laws. If you had taken time when you were going through this educational process, you would have found that even before this country became what it is, because of encouragement from another country, we, the Indian tribes, practiced tribal sovereignty. It was not something that started when the U.S. Supreme Court handed down a very famous decision on a case known as *Worcester* v. *Georgia*. All the U.S. Supreme Court did at that time is simply dip back down into history and come back up with that concept.

There was mention made of the trust and responsibility. The position that the San Carlos Apache Tribe has taken is that further Federal budget cuts would be tantamount to an abandonment by the U.S. Government of its trust responsibilities, not only to the San Carlos Apache Indian Tribe, but to the other American Indian tribes as well. Therefore, the San Carlos Apache Council urgently petitions the executive branch and the Congress of the United States to make a complete and thorough review of an analysis of the impact of any further budget cuts on the San Carlos Apache Tribe and other Native American tribes.

I appreciate the fact that there is at least this committee looking into this particular topic. What about the people who are pushing the so-called New Federalism? Where are they? When are they going to come up and meet the first Americans?

The San Carlos Apache Tribal Council also expresses further opposition to any further reductions in Federal expenditures for the San Carlos Apache Tribe and other Native Americans, and at the same time reminds the Federal Government of its trust responsibilities to Indian tribal governments.

It seems to me that what is happening here is something that I have always feared. Before I get into that, let me make a general statement. It is history that the U.S. Government has attempted genocide on us, the San Carlos Apache Tribe, a number of times. Given that, we are wondering whether what is happening here, the New Federalism, the budget cuts, are not another form of genocide. If so, perhaps this is the Trojan horse that David Stockman talked to the people about.

I believe, Senator, that you can stop this Trojan horse from infiltrating into, in this case, programs that are sponsored by the Indian Health Service. I am sure you are interested in hearing some of the recommendations that were mentioned to me. Some of these things have already been covered by other Indian representatives.

A review of area and headquarters functions. There should be a formal review of each segment of the area office and headquarters functions by service and management, tribes and area staffs, for possibly centralization or elimination. The intent of this recommendation is to have all possible cuts absorbed at these two levels before any are passed on to the service unit level where direct care is provided. I realize these areas consist of good people, but if there are going to be budget cuts, they must remember that we are here for one reason and that is to provide service to the people.

At present Indian Health Service has area and program offices located across Indian country. We request that the possibility of consolidating these offices be thoroughly reviewed before there are any reductions in clinical services. For example, in two States—New Mexico and Arizona—we have the Phoenix area office, the office of research and development at Tucson, the Albuquerque area office, and the Navajo area office. Is it possible to consolidate these offices into one area office and call it the Southwest area office? This could be done also in other parts of Indian country.

We would like to see the community health representative program continue.

Of course, what I said here assumes that there may be budget cuts, but I would like to say that we do not want to see any budget cuts. We would rather see increases in these areas because we are dealing with a life and death situation. It seems like that is the bottom line here because we are dealing with human lives.

I told you earlier that I was going to present a position which has been arrived at by the Intertribal Council of Arizona, and that has to do with the blood quantum issue. It is the position of the Intertribal Council of Arizona that the one-quarter Indian blood requirement would be acceptable with one addition, that whoever meets this first requirement also is a member of a federally recognized tribe as defined in Public Law 93-638.

We will also make available to this committee, within 45 days, recommendations relative to the impact or implementation of such. In other words, we would like to see the legislation refined so that it does what it is meant to do.

I expect by now, after what you have heard from other Indian tribes, as well as from me, you have a question. The way the reductions have been going, on health care being provided to, not only the San Carlos Apache Indian Tribe, but to other Indian tribes, are the Indians going to survive? Perhaps I can give you that answer, but let me borrow the answer from a parable.

It is about a little boy, a little bird, and a guru. This guru was known for his wisdom, foresight, and intelligence. It seemed like he could see through you. This little boy had one hard time trying to trick the guru. Every time he brought up something, the guru knew what it was going to be. He knew the answer. The little boy thought of a ploy. He was finally going to outdo the guru, and he thought of this plan.

He said: I am going to get myself a little bird. I am going to put that little bird in one of my hands. I am going to put it in my hands at my back like this, and I am going to walk up to guru and I am going to ask him, "What have I got in my hand?" and he will probably say, "A little bird." Then I am going to ask him, "Is the little bird dead or alive?" and if he said, "The little bird is dead, then I am going to show him the little bird, and it will be alive, but if he says, "The little bird is alive," then I am going to crush the little bird's head back here, and I am going to show him a dead little bird.

So this one day he came up to the guru and asked those questions, and he said, "What do I have back here?" True to form, the guru said, "A little bird." Is the little bird dead or alive?" True to form, the guru answered, "That is in your hands." To answer your question: Are we going to survive? The answer is in your hands.

Thank you.

Mr. MULKEY. Mr. Chairman, you indicated the Intertribal Council's position on the Colorado River Tribes' proposal. Does that reflect the San Carlos Tribal Council's position also?

Mr. ANDERSON. The tribe has not taken a formal position on this, but I was going over the constitution of the tribes, and it does mention—well, I will read it to you so that will show that it will not affect us drastically. It has to do with article 3. Membership. Section 1. The membership of the San Carlos Tribe shall consist of—I am leaving out A. B. here—all children of one-fourth or more San Carlos Apache Indian blood, born to resident Americans, and all children of one-fourth or more San Carlos Apache Indian blood born to nonresident Americans, if such nonresident Americans declare their intention of maintaining membership within the tribe. Methods have been determined by the ordinance of the council——

Any questions?

Mr. **Taylor**. Yes; earlier in your testimony you testified you had made requests and these funds had been reduced. Were those reductions below the levels of money actually received in the preceding year?

Mr. **Anderson**. Well, in the first place, we were never given what we wanted, and I think that permeated my whole testimony.

Mr. **Taylor**. All right. That clarifies that. That's all the questions I have.

Mr. **Richtman**. I have one question. You discussed the need for a review of consolidating IHS offices. Are you talking about area offices and program offices or just area offices or program offices?

Mr. **Anderson**. I think there just ought to be a review of what lies above the local level. When I say the "local level," I mean the service level, because the service unit is there to supply treatment for people, the local people. The ones that are over here serve in most cases as a conduit to what is supposed to be another area, but they are not all conduits. Sometimes it is a bottleneck.

Mr. **Richtman**. Would you support the reduction of the number of area offices if it is a way of saving administrative costs?

Mr. **Anderson**. I think we have had a very able and well-minded area director over in the Phoenix area. I have heard statements from him to the effect that if it means the difference between giving care over to the local level, then there would be administrative reductions at the area level.

Mr. **Richtman**. I am not talking about reductions at the area level. I am talking about a reduction in the number of area offices.

Mr. **Anderson**. That would be one possibility, as far as a review is concerned, but I am not talking about all. I am saying there ought to be a review. One thing that I guess I took for granted here is that there ought to be a consultation process. Just because I said we ought to do away with certain areas does not mean that should be done. I think all of us should put our heads together and see what is working for all those concerned.

Mr. **Mulkey**. Thank you.

Tonto Apache Tribe, Melton Campbell, chairman.

Not here?

OK, is Dr. Exendine still here? If he is out there talking to somebody, could you ask him to come in.

Dr. Exendine, if you would like to come on down and bring any of your colleagues that may be here with you.

Dr. **Exendine**. I think maybe I can handle it. If I can not I will holler.

Mr. MULKEY. The Colorado River Tribes made several recommendations, and I think that we might ask if you have any reaction to them. If you do not, at this time, maybe, you can react later. We would like you to submit it when you can.

TESTIMONY OF DR. JOSEPH EXENDINE, RESUMED

Dr. EXENDINE. I would be happy to answer them here if you will just go through them. Whatever you wish.

Mr. MULKEY. Which one do you want to start with?

How about the requirement: A minimum of 25 percent of all non-service unit, IHS, or agency, BIA, positions be transferred to the service unit or agency?

Dr. EXENDINE. Basically—let me put it this way. Right now the difficultly of that would be that it would take more people to run a service unit than we have right now. There is a possibility on the program side, but we have got to stop and think that our facilities in the service unit, for the most part, are not large enough to put a personnel office in there, a complete line officer. The economy dictates we have to centralize our offices and our services. Therefore, we do not have to duplicate them. It would take us three times the services of people if we went out and tried to duplicate a private hospital. Private hospitals have their own personnel and their own money, and their own finance offices and stuff along this line.

Mr. MULKEY. But, as I understand the proposal, they have the flexibility to determine how to use those positions, and as I understand you, you are assuming that these positions would be for certain types of jobs. Is that accurate? With their positions they would like flexibility, so they might not want to do what you are suggesting.

Dr. EXENDINE. I think probably, and for the most part, right now they do have the prerogative of working with a service unit and making those types of decisions in determining if they need this type of individual or that type of individual.

You heard mentioned this resource requirement, and what has taken place here, we take a look at the national standards. We take the projections and workloads and utilization in there and variables to see what is lacking of the total resources and make our adjustments in there. So, for all practical purposes we do have this. Now just arbitrarily taking a position and saying we are going to use it here, use it there, could be quite dangerous from their standpoint, because you have got to maintain a certain staff for accreditation under the Joint Commission Accreditation of Hospitals or under the medicare program. We want to maintain a minimal staff so we are able to collect medicare and medicaid, so if we are not able to put a lab in there or, say, a medical records technician, take that position and put it someplace else, all of a sudden the Joint Commission of Accreditation of Hospitals would not accredit us. So, there are minimum standards we have to comply with in order for us to maintain the quality of service.

Mr. MULKEY. Where are you talking about the quality of service you have to comply with, for instance, at Parker—are you talking about the hospital at Parker?

Dr. Exendine. Anyplace. Just anyplace.

Mr. Mulkey. You do not think the tribe would be able to do that?

Dr. Exendine. Yes, surely.

Mr. Mulkey. I mean if they had this ability or 25 percent of these positions were tranferred, would it not be in their best interest to keep whatever they need there in order to be accredited?

Dr. Exendine. I think probably there needs to be some clarification on that 25 percent. If we took 25 percent of the area staff, and I assume that is what we are talking about here, unless we are sending it to Colorado River, and, therefore, we take another 25 percent, something along this line, we would reduce our ability to assist the other tribes, and I guess—again, let me reemphasize there is a core, a basic staff, that is needed in order to perform the administrative functions in a particular area. Now that does not mean that—as indicated earlier in the testimony—that we are not taking a look at consolidating some of the areas along this line and possibly eliminating some of the administrative program staff along this line.

Mr. Mulkey. Mr. Crawford has a comment.

Mr. Crawford. First of all, what we were attempting to do was have some delegation of authority and some flexibility in a service unit. Your comment about a tribe having this ability now, I think, is somewhat misleading. We are not asking for 25 percent of all those positions to go to Parker. We are saying they should be divided among all the service units, and if we are talking about 40 positions at the Phoenix area, the maximum is probably four positions to any one service unit.

What we want, Dr. Exendine, is the ability to say, if there is a position available, it will be a position—it will be a nurse—it will be whatever we deem we need. We are very well aware of the JCAH requirements. We know it is in our best interest to maintain that, and we understand that Dr. Blue Spruce has a list of at least 37 positions he could eliminate and still maintain that. The requests are not unrealistic, and we are not trying to take over anything. But, that is a starting point, and I think we have to have a starting point.

Dr. Exendine. Rather than get into a debate across the table, let me make a recommendation that we submit to you a detailed breakdown on this recommendation and leave it to your discretion on how you handle it.

Mr. Mulkey. That would be fine. We appreciate that.

Yes, Doctor.

Dr. Blue Spruce. The comment I would like to make, I do support that, but I do know and I have publicly made the statement, we do have physicians in the positions in the area office that if we could eliminate the incumbents and have the positions go out to the service unit to provide direct care, we would. The service unit identifying the need. However, there are those constraints placed upon us due to the Civil Service Reform Act that disallow us to take certain positions, regardless of what they are, and transfer them into other programs or to even allow us, in some instances, to lapse them. Then, of course, that same act has further constraints on us in that if we were to do anything other than the way things are presently mandated for us to do or not to do, this would impinge upon the individual's personal personnel rights as well as the fact we would have to deal with the unions and how they would feel about it.

Mr. TAYLOR. I would like to ask one thing. On this report or flier you are going to submit to us, to the extent constraints are imposed by other civil service laws, that should be pointed out and, preferably, with some recommendations for some reform. Constantly, when we deal with this administration, overall, we come up against procurement ranks and personnel laws, but that should not be a final answer. What we then need is the recommendation for reform, which will be necessary to facilitate loosening this thing up.

During the break I was told that during the period since 1980 the staff in the area level has increased from 129 to 160. That seems a strange period of time for such an increase to be occurring, and I am, frankly, curious why there has been an increase in staff at the area level while there has been a staff decrease at the service unit.

Dr. BLUE SPRUCE. I do not want to get caught here in testimony with denying or agreeing, but I would have to say that there has been increases everywhere. If I were to truly bring out the files, I would say that over the long haul it has been just the opposite. There has been growth in the service units with comparatively less increases of the area office That sounds like, you know, a little double talk, but I would not want to say that that is completely accurate.

Dr. Exendine did touch upon a very important point, and that is with the responsibilities that have grown for area management there has been a need to grow accordingly. Of course, that growth is what has stopped, but there are many administrative matters that are handled in the area office that we cannot afford to duplicate out in the service unit, and so with the growth of the programs, there has had to be additional administrative management and growth in the area office to administer those programs.

Mr. MULKEY. Could you respond to the Colorado River tribes' proposal on the blood eligibility requirement?

Dr. EXENDINE. With mixed emotions. Probably the first thing is that I would strongly recommend that there be—and I think he recommended it also—that there should be a very detailed study on this issue. It is a very tough issue. I think, eventually, in some places, it may pit tribe against tribe in the United States. This leads me to say that probably each individual tribe should be able to protect its own sovereignty, and one of the classic things, it seems like history has been able to do is to try to keep tribes off balance and competing against themselves and not being in unity. Therefore, they have a set way to control them, so I reemphasize again. I think each tribe probably should be able to take their own private sovereignty on this issue, protect their own sovereignty, and let them each make their own decision on this. There are many, many questions that come to mind. We are talking about sliding fee scales; talking about benefit packages, and things along this line, and I would like to caution the committee and the tribes who are doing the study on this to not only think about the short range benefits, but I would like to have them take into consideration the long-range impact on what this may be. I think all of us have been around long enough to see that anytime we start talking about a sliding fee or services and using existing resources and things along this line, there seems to be an agenda that comes out of the woodwork that lists the needs and this is to be used as an offset against the existing budget. I think you gentlemen have all seen this over the years, so what this means is once we start collecting money on a sliding scale, that will not just supplement our budget, it will offset it, and I think that eventually—it will not be in the near future, but it would have quite an impact on us over the years.

I think the second thing, the thing that probably frightens me most, is the long-range impact, and I am not really quite sure what it means to some tribes. It may be beneficial to some, and to others it may not be beneficial.

I would like to throw the word in here—to keep the word "termination" in mind when you start talking about long-range impacts on this, because I think most of us have been through—we remember some of the omnibus bills written in the 1950's and the things that took place along that line. What it taught us, and I caution you—I think a very detailed study should be done on it. I think the tribes should have the opportunity to make recommendations before any legislation is proposed on it. I do not have the answer. I really do not.

As you know, Congress has been trying to—in administration over the years—has been trying to identify an Indian for 300 years. But seriously, I would like to again urge that the tribes have some final decision in the recommendations for the legislation if it is imposed or recommended.

Mr. **Mulkey**. Dr. Blue Spruce.

Dr. **Blue Spruce**. Yes, if we are to live with these traumatic budget reductions for any period of time, one has to take a look at the total eligibility issue. Over the past 10 years, the Indian Health Service has grown so that it could bring a lot of services to a lot of people, and it has come to where now it supplies services to almost anybody who will self-identify themselves as being Indian. Those of us who were Indian, before being Indian was cool, remember that there was a specific health service to be provided only to those reservation-based Indians. In recent years, as a manager, I have seen what being put in a position of very little resources versus a tremendous demand in the Phoenix area is, and I speak on behalf of that area. We see it more dramatically as we deal with the population here in the metropolitan Phoenix area. At our Phoenix Indian Medical Center, as an Indian, personally, myself, it concerns me to walk through the waiting rooms or through the treatment rooms and see very many people that I would have difficulty identifying with as being Indian, and then when I will stop and talk to Indian people of fuller blood, they will constantly bring up this subject.

Is the Indian Health Service going to continue to serve people that are of less than one-half or less than one-quarter Indian blood? I would have to say if the dollar amounts are being cut to a minimum and the demand is going to be more than we can serve, there has to be a total investigation of this eligibility issue, and if Congress will go back into its archives and take a look at the original statements by which the Indian Health Service was set up to supply services, I think you will find some of the answers, and that the primary recipient was to be a reservation-based Indian, but as an area director and a member of the Federal Government, I would have to turn the challenge back to the Indian tribes. It is they, in the final analysis, who will have to identify who are members of their respective tribes, blood quantum or otherwise.

Mr. **MULKEY**. Dr. Exendine, would it be within IHS' capabilities to try and determine how many people we are talking about that are presently receiving services that would not receive services unless they paid something under the Colorado River Tribes' proposal? I'm not asking is there any. Is there any way that could be done?

Dr. **EXENDINE**. It could be done. It would be an extensive study. You could have a situation where individuals come in, and take a look at it from that standpoint. The answer to that is, it could be done, but it would be an extensive study. Another point I would like to make, we can bill the individual, but we have to have legal authority to demand payment from him. There probably would have to be two things. No. 1 would be that legislation would have to be passed that we have the authority to bill the individual capable of paying No. 2, I believe Mr. Crawford indicated that the money remain at the service unit. The way it is set up now, it reverts back to the Treasury. Those two things need to be thought out very carefully.

Mr. **TAYLOR**. I understand the National Indian Health Board may be meeting in Washington next week and this issue may be discussed at that time. Have you been apprised of that?

Dr. **EXENDINE**. I am aware that they are meeting, and I have not seen the agenda, but I am pretty confident it will come up.

Mr. **TAYLOR**. Frankly, I would hope if they do bring up this issue, you would be invited to meet with them and discuss the problem.

Dr. **EXENDINE**. Be happy to.

Mr. **TAYLOR**. It seems to me that much of the concern that has been generated here is occurring as a result of what is happening in—I think it is four field service units in Oklahoma—where the testimony is that there are 90,000 additional people that are all of a sudden going to become eligible. Frankly, I do find that a matter of great concern. I do not think some of the testimony presented here was quite accurate in the role of tribal chairmen and as opposed to what may be happening with respect to the BIA issue and certificates of Indian blood, the CIB's. I understand some of the tribal chairmen have been complaining about that and that there has been a promiscuous issuance of these things.

Dr. **EXENDINE**. There is no question that it needs to be looked into.

Mr. **TAYLOR**. In the report you are going to submit to us, would you provide us with information with respect to the extent the service-eligible population has grown since 1977. That was the date used, and particularly the contention that, apparently, 90,000 people are ready to descend on this fund and tie up everybody's health resources.

Dr. **EXENDINE**. I can give the actual workload that has increased since 1977. I think at this particular time we would be remiss if I said to you that I could give you what impact this 90,000 would have because maybe only 30,000 would show up. But I know we have had experiences over the last couple of years, and I think the Cherokee is the one that has lowered the blood quantum. I think Mr. Crawford is of that tribe, so he is very knowledgeable. I think we can give you actual workload, especially at Tahlequah and Claremore. I can go back to 1977.

Mr. **Taylor**. How about Tahlequah and Ada?

Dr. **Exendine**. Ada, I think there is not sufficient time, because we just opened that up a year and a half ago. I don't think that is enough time to give you an adequate workload on that.

Mr. **Mulkey**. Dr. Exendine, we have indicated further questions which we would like you to give us answers to for the record. I believe Mr. Richtman and Mr. Taylor have given you those, and I appreciate your staying around so that we could talk with you about some of these proposals.[1]

At this time the hearing is adjourned, subject to call of the Chair.

Thank you all for coming.

[Whereupon, at 2:15 p.m., the hearing was adjourned.]

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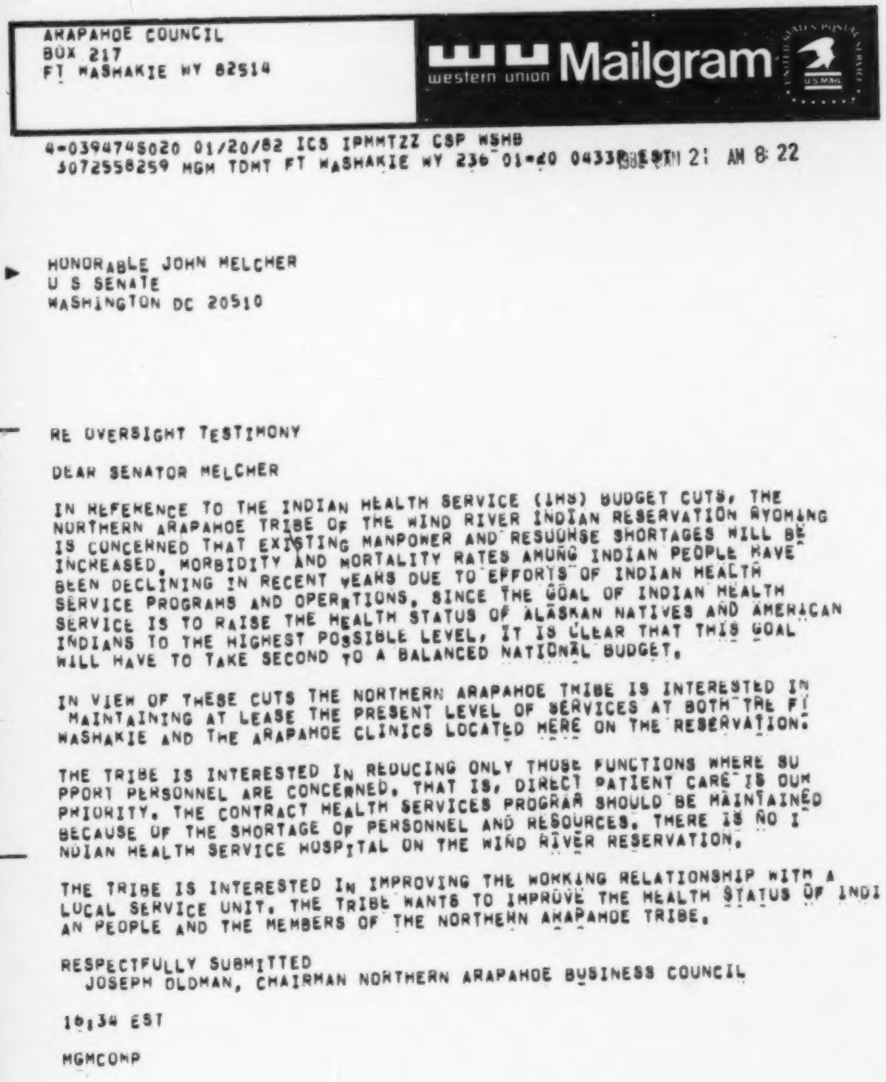
[1] Not received at time of printing.

APPENDIX

Additional Material Received for the Record



ARAPAHOE COUNCIL
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HONORABLE JOHN MELCHER
U S SENATE
WASHINGTON DC 20510

RE OVERSIGHT TESTIMONY

DEAR SENATOR MELCHER

IN REFERENCE TO THE INDIAN HEALTH SERVICE (IHS) BUDGET CUTS, THE NORTHERN ARAPAHOE TRIBE OF THE WIND RIVER INDIAN RESERVATION WYOMING IS CONCERNED THAT EXISTING MANPOWER AND RESOURCE SHORTAGES WILL BE INCREASED. MORBIDITY AND MORTALITY RATES AMONG INDIAN PEOPLE HAVE BEEN DECLINING IN RECENT YEARS DUE TO EFFORTS OF INDIAN HEALTH SERVICE PROGRAMS AND OPERATIONS. SINCE THE GOAL OF INDIAN HEALTH SERVICE IS TO RAISE THE HEALTH STATUS OF ALASKAN NATIVES AND AMERICAN INDIANS TO THE HIGHEST POSSIBLE LEVEL, IT IS CLEAR THAT THIS GOAL WILL HAVE TO TAKE SECOND TO A BALANCED NATIONAL BUDGET.

IN VIEW OF THESE CUTS THE NORTHERN ARAPAHOE TRIBE IS INTERESTED IN MAINTAINING AT LEASE THE PRESENT LEVEL OF SERVICES AT BOTH THE FT WASHAKIE AND THE ARAPAHOE CLINICS LOCATED HERE ON THE RESERVATION.

THE TRIBE IS INTERESTED IN REDUCING ONLY THOSE FUNCTIONS WHERE SUPPORT PERSONNEL ARE CONCERNED. THAT IS, DIRECT PATIENT CARE IS OUR PRIORITY. THE CONTRACT HEALTH SERVICES PROGRAM SHOULD BE MAINTAINED BECAUSE OF THE SHORTAGE OF PERSONNEL AND RESOURCES. THERE IS NO INDIAN HEALTH SERVICE HOSPITAL ON THE WIND RIVER RESERVATION.

THE TRIBE IS INTERESTED IN IMPROVING THE WORKING RELATIONSHIP WITH A LOCAL SERVICE UNIT. THE TRIBE WANTS TO IMPROVE THE HEALTH STATUS OF INDIAN PEOPLE AND THE MEMBERS OF THE NORTHERN ARAPAHOE TRIBE.

RESPECTFULLY SUBMITTED
JOSEPH OLDMAN, CHAIRMAN NORTHERN ARAPAHOE BUSINESS COUNCIL

16:34 EST

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0351P EST 15:51 EST

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HONORABLE WILLIAM S COHEN RPT DLY MGM, DLX
SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
CAPITOL ONE DC

DEAR SENATOR COHEN

THE SHOSHONE AND ARAPAHOE TRIBES APPRECIATE THE OPPORTUNITY TO COMMENT ON THE IMPACT THE FISCAL YEAR 1982 BUDGET REDUCTIONS IN INDIAN HEALTH SERVICE PROGRAMS WILL HAVE ON OUR RESERVATIONS.

IT IS DIFFICULT TO ADDRESS THIS PROBLEM COMPLETELY AS WE HAVE NOT YET RECEIVED THE FISCAL YEAR 1982 BUDGET. HOWEVER BASED UPON CONGRESSIONAL ACTION, WE ARE SUBMITTING THE ATTACHED TESTIMONY.

SINCERELY YOURS,
JOSEPH CLOMAN
CHAIRMAN, ARAPAHOE BUSINESS COUNCIL AND,
ROBERT N HARRIS SR
CHAIRMAN, SHOSHONE BUSINESS COUNCIL

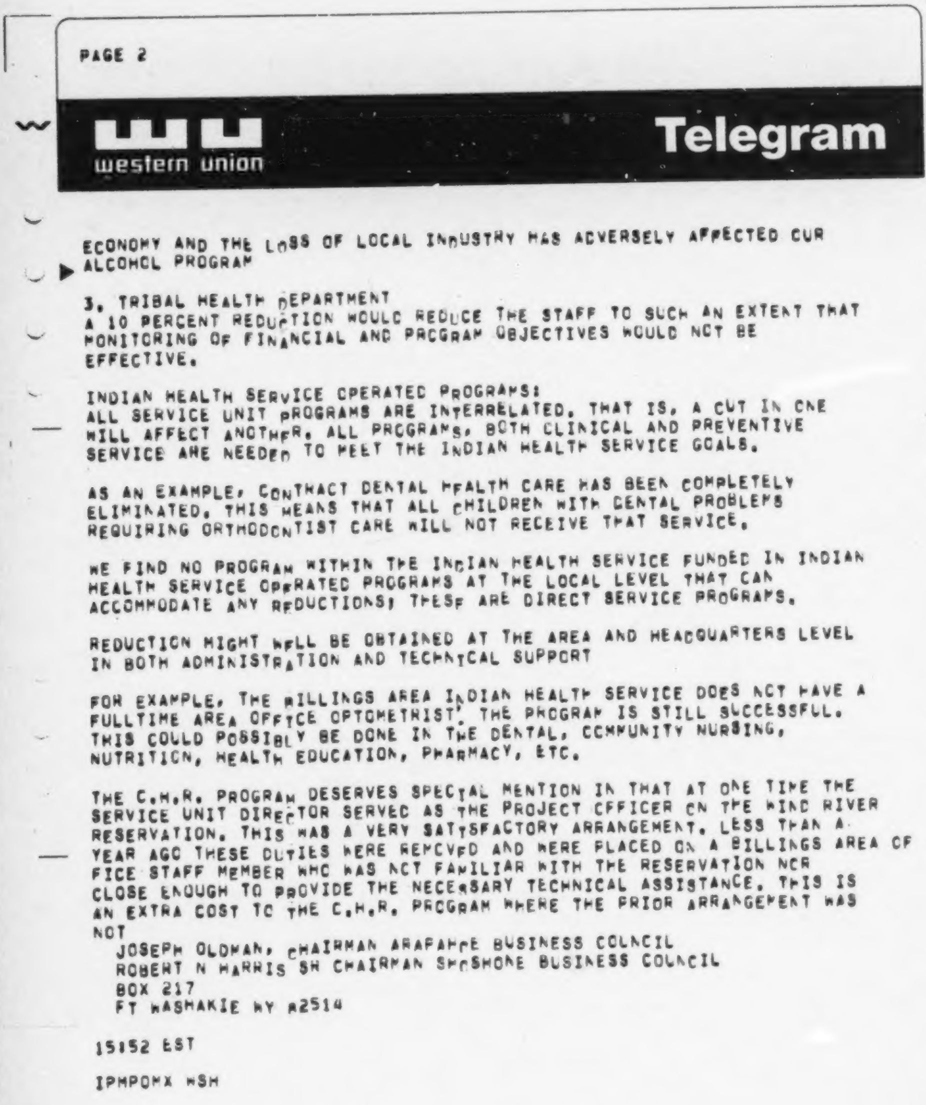
TESTIMONY OF THE SHOSHONE AND ARAPAHOE TRIBES

ON THE IMPACT OF FISCAL YEAR 1982 BUDGET REDUCTIONS ON INDIAN HEALTH SERVICE FUNDED AND OPERATED PROGRAMS

INTRODUCTION:
PRESENTLY WE ARE OPERATING ON A TENTATIVE 10 PERCENT REDUCTION FROM FISCAL YEAR 1981. WE ARE AWARE FROM THE HISTORY OF ADMINISTRATION AND CONGRESSIONAL ACTION INDIAN HEALTH SERVICE DOCUMENT THAT THERE ARE REDUCTIONS WHICH EXCEED 10 PERCENT

INDIAN HEALTH SERVICE FUNDED PROGRAMS:
1, COMMUNITY HEALTH REPRESENTATIVE PROGRAMS,
WE ARE APPARENTLY GOING TO TAKE A 21 PERCENT REDUCTION IN THIS PROGRAM. THE IMPACT WILL BE FELT IN TRANSPORATION OF THE ELDERLY AND HANDICAPPED TO THE MEDICAL FACILITIES, EYEGLASSES, E.N.T. (EAR NOSE AND THROAT), DENTAL, NURSING, SANITATION AND HEMODIALYSIS SERVICES WOULD ALL BE REDUCED PROPORTIONATELY

2, ALCOHOL PROGRAMS
IT APPEARS ON PAPER THAT A SMALL INCREASE WAS MADE; HOWEVER, WHEN CONSIDERING THE INFLATION RATE OF 18 PERCENT WE EFFECTIVELY HAVE EXPERIENCED A FUNDING REDUCTION. THE COMBINED EFFECTS OF THE NATIONAL



PAGE 2

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ECONOMY AND THE LOSS OF LOCAL INDUSTRY HAS ADVERSELY AFFECTED OUR ALCOHOL PROGRAM

3. TRIBAL HEALTH DEPARTMENT
A 10 PERCENT REDUCTION WOULD REDUCE THE STAFF TO SUCH AN EXTENT THAT MONITORING OF FINANCIAL AND PROGRAM OBJECTIVES WOULD NOT BE EFFECTIVE.

INDIAN HEALTH SERVICE OPERATED PROGRAMS:
ALL SERVICE UNIT PROGRAMS ARE INTERRELATED. THAT IS, A CUT IN ONE WILL AFFECT ANOTHER. ALL PROGRAMS, BOTH CLINICAL AND PREVENTIVE SERVICE ARE NEEDED TO MEET THE INDIAN HEALTH SERVICE GOALS.

AS AN EXAMPLE, CONTRACT DENTAL HEALTH CARE HAS BEEN COMPLETELY ELIMINATED. THIS MEANS THAT ALL CHILDREN WITH DENTAL PROBLEMS REQUIRING ORTHODONTIST CARE WILL NOT RECEIVE THAT SERVICE.

WE FIND NO PROGRAM WITHIN THE INDIAN HEALTH SERVICE FUNDED IN INDIAN HEALTH SERVICE OPERATED PROGRAMS AT THE LOCAL LEVEL THAT CAN ACCOMMODATE ANY REDUCTIONS; THESE ARE DIRECT SERVICE PROGRAMS.

REDUCTION MIGHT WELL BE OBTAINED AT THE AREA AND HEADQUARTERS LEVEL IN BOTH ADMINISTRATION AND TECHNICAL SUPPORT

FOR EXAMPLE, THE BILLINGS AREA INDIAN HEALTH SERVICE DOES NOT HAVE A FULLTIME AREA OFFICE OPTOMETRIST. THE PROGRAM IS STILL SUCCESSFUL. THIS COULD POSSIBLY BE DONE IN THE DENTAL, COMMUNITY NURSING, NUTRITION, HEALTH EDUCATION, PHARMACY, ETC.

THE C.H.R. PROGRAM DESERVES SPECIAL MENTION IN THAT AT ONE TIME THE SERVICE UNIT DIRECTOR SERVED AS THE PROJECT OFFICER ON THE WIND RIVER RESERVATION. THIS WAS A VERY SATISFACTORY ARRANGEMENT. LESS THAN A YEAR AGO THESE DUTIES WERE REMOVED AND WERE PLACED ON A BILLINGS AREA OFFICE STAFF MEMBER WHO WAS NOT FAMILIAR WITH THE RESERVATION NOR CLOSE ENOUGH TO PROVIDE THE NECESSARY TECHNICAL ASSISTANCE. THIS IS AN EXTRA COST TO THE C.H.R. PROGRAM WHERE THE PRIOR ARRANGEMENT WAS NOT

JOSEPH OLDMAN, CHAIRMAN ARAPAHOE BUSINESS COUNCIL
ROBERT N HARRIS SR CHAIRMAN SHOSHONE BUSINESS COUNCIL
BOX 217
FT WASHAKIE WY 82514

15:52 EST

IPMPOMX WSH

W.U. 5248A (R5-79)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

Officer in Charge
PHS Indian School Health Center
Flandreau, South Dakota

Refer to: Budget reduction impact

Attn:
Senate Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

The Flandreau Santee Sioux are served by an Indian Health Service Clinic staffed by nurses providing dental services, health maintenance and health prevention services. The service area is Moody County, South Dakota and includes a high school boarding school and the Flandreau Sioux with 8,000 visits per year. Medical services have been provided in the past by direct support from IHS for contract medical care as well as utilizing Medicaid and Medicare.

Patients with problems requiring medical care are advised to see a doctor and also advised that there can be no contract health to pay for their care unless it is life threatening. It is not known what exactly is happening with these patients as they do not return; however numerous calls are received from providers requesting authorizations for payment.

It is felt that some of the patients are seeing a doctor but are not paying for their care. Various providers are establishing a policy of cash payment if there is an outstanding past bill.

We see this new policy as severely limiting any medical services and potentially life threatening situations becoming indeed life threatening at a greater frequency and also at a higher cost.

I have been on a three month educational leave of absence and in reviewing files and outstanding bills see the forementioned pattern occurring.

Judy C. Jones

Judy C. Jones, RNC
Clinical Nurse

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

Officer in Charge
PHS Indian School Health Center
Flandreau, South Dakota

Refer to: Budget reduction impact

Attention:
Senate Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

Due to budget cuts in Indian Health Services we, here at the health center, have seen and are seeing a decrease in the interest of one's own health care. The Indian people are neglecting medical problems that cannot be taken care of by our staff. We, as nurses, can only do so much with providing maintenance and preventive health care.

Our health center is a satellite of Sisseton P.H.S. They have a public health hospital there with two in house physicians. We have only Registered Nurses. Our town medical doctor is contracted to provide services for only Flandreau boarding school students, not Santee Sioux Tribal members.

Now we are operating under Priority I, life threatening emergencies only. Any medical condition that goes ignored for any length of time may lead to a life threatening situation which in return could cost ten times as much as one or two visits to a physician would.

The Indian children also have to be remembered in these cutbacks. Childhood diseases can be potentially life threatening if ignored for even a short period. Why should they suffer especially if it is a condition that may lead to a permanent disability?

I, myself, have worked here for four months and have had difficult situations arise due to various Indian patients neglecting and forgetting doctors appointments, because of them knowing IHS is not paying for it.

Sincerely,

Pat Johanson RN

Pat Johanson, R.N.
Acting Officer in Charge

Flandreau Santee Sioux Tribe
Box 283
Flandreau, South Dakota 57028

January 21, 1982

Senator William S. Cohen
Chairman-Senate Select Committee on Indian Affairs
6313 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Cohen:

I wish to thank you for your invitation to testify before the Senate Select Committee on Indian Affairs in Billings, Montana on December 21, 1981. Our tribe was unable to be present and for this reason I am enclosing written testimony for the Committee's consideration.

The Flandreau Santee Sioux Tribe, as other tribes, is very concerned over the future of the Indian Health Service and Indian Housing. We have already been forced to absorb serious cuts in both programs. Further cuts in the health area will cause a reduction in the quality and quantity of services provided. The Flandreau Santee Sioux Tribe has a housing program which is less than five years old and we are anxious to continue our progress in this area.

We appreciate this opportunity to express our views on these important matters. We would like to receive a copy of the Committee's findings when they become available.

Sincerely,

George L. Allen

George L. Allen, Sr.
Tribal Chairman
Flandreau Santee Sioux Tribe

JRJ:ljb

Flandreau Santee Sioux Tribe
Tribal Health Department
Box 292
Flandreau, S.D. 57028

December 30, 1981

Senate Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

Refer to: Budget Reduction Impact

This public health service clinic offers the Flandreau Santee Sioux maintenance and preventive health services along with dental services. We also service a high school boarding school. The staff consists of Registered Nurses only. There is no in house physician. Prior to October 1981 any contract medical care was paid by Indian Health Service. At this time any patient requiring referral to a physician must be sent out of the facility for services. The patient is advised that there is no contract health to pay for their care unless it is a life threatening situation.

Some of these people fail to keep doctor appointments, due to the fact they have no funds to cover the cost. Others have past bills which some providers request payment on before they will examine the patient again. Most of these people do not return to our clinic so we do not know if the medical problems have been resolved or simply neglected.

Since this program was our only source of funding we feel it greatly limits the provision of medical services to the people. Cut backs in the budget have decreased our ability to provide preventive medicine. Potential life threatening situations may become life threatening and inflict greater inconvenience and cost upon the patient.

Kathy Doyle RN

Kathy Doyle, R.N.
Santee Sioux Tribal Nurse

Flandreau Santee Sioux Tribe
Tribal Health Department
Box 292
Flandreau, S.D. 57028

December 21, 1982

United States Senate
Select Committe on Indian Affairs
Washington, DC

Re: Impact of fiscal year 1982 budget reductions in Indian Health Service funded and operated programs

Since the 1982 budget allocation it seems that the Indian programs have been promised monies that continue to be reduced as each month goes by. As of July 1, 1981 the Flandreau Santee Sioux Tribe was allocated Equity Health Care Funds to upgrade their health service in deficient areas. As it has happened, those funds are being used to just keep our health care at its present deficient level because all other health programs are being slashed. Some of the Indian people are being forced to go without health care because they absolutely cannot afford to take care of themselves. The people that really suffer are the elderly on a fixed income and the very small children who are paying for the mistakes of adults.

As you consider budget cuts, please study what those cuts will do to the people effected. The Flandreau Santee Sioux Tribe would be glad to visit with anyone about the impacts of the budget cuts, or come to our reservation and see for yourself how the people are being effected. But most important, please; know what these budget cuts mean to the people before you act on saving money without really knowing what consequences you are presenting.

Sincerely,
Rose Stee
Rose Stee
Health Administrator
Flandreau Santee Sioux Tribe

Ft. McDowell Mohave-Apache
Indian Community
P.O. Box 17779
Fountain Hills, Arizona 85268

February 11, 1982

Senator Dennis DeConcini
1208 Dirksen Senate Office Blding.
Washington, D.C. 20510

Senator DeConcini:

We have been informed that our tribal Indian school will close in fiscal year 1983 due to current budget cuts. We are excluded from the Department of Interior budget for fiscal year 1983. There will be no school at Ft. McDowell. There will be no education for our children. We have been dropped. As a result, our children will run unattended on the reservation until they are six years old. Then they will be bused 50 miles to a first grade in Mesa to a traditional white school. They will be expected to conform to the majority society culture without preparation.

The Ft. McDowell school serves all the young children of the Ft. McDowell reservation aged 0-6. Forty-six children are currently in the program (total reservation population is 390). This parent initiated program began in 1974. Prior to this time, children were dumped into first grade in a traditional school system a one hour bus ride away from their isolated reservation home.

The Ft. McDowell educational program has been a model project for the past eight years. Prior to the preschool's inception, the young children of the reservation were set up for failure in the traditional primary schools. The confusion and cultural shock of the Indian children is evidenced in pass-retention performance.

The drop out rate between 1967-1974 was 70%. The drop out rate after the Ft. McDowell Preschool began continues to be 0. The 100% retention rate reflects our parental support and may have future effects on the high school graduation rate.

Additional data (November 1981) shows that the Ft. McDowell program had much positive impact upon successful performance in public school in the areas of grammar (language arts), math, and reading. Ft. McDowell Preschool graduates scored above the national average in all areas and significantly above average in grammar scoring at an 8 stanine level. The Ft. McDowell Preschool has prepared the young children to not only weather their encounters with public education but to enable many to thrive in the majority society yet preserving their cultural heritage.

The Ft. McDowell Preschool was funded 100% under the Department of Interior, Bureau of Indian Affairs.
Implications of the zero funding level slapped to us are:

1. School closure - NO EDUCATIONAL PROGRAM
2. Projected increased primary school drop out
3. Lack of preparation for first grade school entrance possibly resulting in the destructive cycle of school failure, dropping out, getting into serious trouble, being shipped off to boarding schools.

The Ft. McDowell reservation is asking that our funding be restored or that the Bureau of Indian Affairs identify alternate sources of funding. We are requesting any information you can give us concerning a proposed master plan "safety net" program suggested by David Stockman. This plan, not contrary to President Reagan's economic policy was to have assured that programs such as our small yet highly successful one at Ft. McDowell were not abandoned.

Sincerely,

Norman Austin
Tribal Chairman
Ft. McDowell Indian
Community

TESTIMONY
FOR
OVERSIGHT HEARING
U. S. SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

February 15, 1982
Phoenix, Arizona

SUBJECT: The Impact of Fiscal Year 1982 Budget Reductions on Indian Health Service Funded and Operated Programs in Nevada

Presented by:

Jerry Millett, Chairman
Duckwater Tribal Council

and

Inter-Tribal Council of Nevada
Executive Board Health Committee

This testimony concerns the impact of the Indian Health Service's FY 82 budget on the medical services available to Nevada's Indians. It cannot be adequately understood without background knowledge of the inherent problems of providing medical services in Rural Nevada.

The physical constraints of isolation, sparse populations, topographical and climatic conditions all have an adverse bearing on key components of the health delivery system. Transportation, communication, accessibility to care, consumer education, patient follow-up, response time to medical emergencies, cost effective services, and attraction of health providers all present major difficulties.

Nevada is over 110,000 square miles. In fact, Massachusetts, New Jersey, New Hampshire, Vermont, Connecticut, Delaware, Rhode Island, Maryland, Maine, the District of Columbia and Hawaii could all fit into its boundaries with 2500 square miles to spare!

Vast distances separate the scattered, sparse populations, presenting an enormous logistics problem in delivering adequate care. The Federal Government recognized this fact by designating Nevada as a Contract Health Services Delivery Area.

Nevada has two IHS hospitals: Schurz in Western Nevada and Owyhee in Northeastern Nevada. Eighty-six percent (86%) of the tribal communities are at least an one and a half hours from the IHS hospitals; the average travel time for all tribes is two and half hours one way!

The Schurz and Owhyee facilities only offer primary and convalescent medical care. These facilities do not provide obstetrical, surgical, pediatric, or secondary medical services. Less than 50% of all conditions requiring hospitalization can be treated at these IHS facilities.

The balance of medical services must be provided through Contract Health Services funds. The high demand on CHS dollars and the skyrocketing costs of health care have not been matched by similar increases to the CHS budget. This has resulted in denials of service and backlogging of necessary medical care. Problems that initially are not critical often develop into more serious cases due to the lag in treatment time. The severe strain on the CHS budget in Nevada has forced a service unit policy of only providing emergency care halfway through the fiscal year. In 1981, both service unit's ran completely out of funds by September and no services were provided at all.

Some CHS denials during last September included: an 85-mile ambulance run for an accident victim, the re-setting of a fractured jaw, a heart attack victim's stay in Intensive Care, and an emergency appendectomy.

At the close of FY 81, the Service Units estimated that $103,000. in surgical funds and over $282,000 in CHS funds were needed to cover unmet needs. Forty-seven individuals were unable to have surgical operations due to a lack of funds. Nevada's Owyhee and Schurz Service Units were 2 of only 3 in the Phoenix Area with significant backlogs of needed surgeries. Using first quarter FY 82 funds to cover the 1981 medical needs will compound the dilemma for this fiscal year since funds allocated do not even meet inflation's costs. The CHS budget only realized a 9% increase over 1981 obligations, inflation in the medical industry is currently at 17%.

The closure of the PHS facility in San Francisco will introduce an added $250,000 burden to the Contract Health Service budget. Nevada's Indians have very limited access to the Phoenix Indian Medical Center.

Despite the lack of services available through IHS, an estimated eighty percent (80%) of the health services received are either provided for or purchased by IHS. A small percentage of the health care is purchased through medicare (4%) or private insurance (5%).*

The majority of Indians in our state cannot afford to purchase health care; an average of 66% of our people are unemployed or earn less than $7000 per annum.**

As Chairman of the Executive Board Health Committee, I am asking Congress to review the critical deficit of health services available to Nevada's Indian population. Ninety(90%) of our tribes are classified in level four of deficiency (61-80%) as defined by the Resource Requirement Methodology. Most of the tribes are eligible to receive Equity Health Funds in 1982 but we haven't seen any funds thus far.

Five-hundred and ninety-five thousand dollars ($595,000) in Contract Service funds are needed to cover both Service Unit's client's unmet medical needs from 1981. Nine-hundred and eleven thousand dollars ($911,000) in Clinical Service funds are needed to keep the doors open of our two IHS hospitals in Nevada. We urge Congress to either earmark these funds to Nevada or follow through on it's directive to IHS to develop methodologies to redistribute the base program and equity funds so at least all tribes can receive similar services.

*Survey included in Tribal Specific Health Plans

**Report of Labor Force, Dept, of Interior, BIA, April,1981

The tribal chairmen of Nevada are deeply concerned about the threat to preventive health services if Congress slashes the Community Health Representative program budget below the 1981 funding levels! In order to compensate for the lack of available medical services in Nevada, PAIHS, along with the tribes, developed a strong preventive health program consisting of direct services and health education. These programs received a serious blow to their ability to provide consistent and skilled care to the ill, infirm, and high risk groups when Congress voted for a 20% slash in the CHR 1982 budget.

IHS ignored Congress's directive to reduce the CHR program only in areas which have higher concentrations of health personnel and clinics or hospitals -- all CHR programs were cut the full amount across the board. Nevada's outreach medical services are almost entirely dependent on CHR funded programs. An analysis of the unmet need for Field Health Services for Nevada tribes reveals a 92% deficiency level.*

Travel restrictions for IHS medical staff and the curtailment of field clinics in 1981 have made the services of CHR staff critical in the delivery of direct health care.

Due to the large numbers of elderly and infirm in Nevada, IHS established an In-Home Health Service Program to provide direct health care as an alternative to institutionalization. This program has proven to be both cost-effective and cost-beneficial, providing skilled nursing care in the homes for 10% of the cost incurred with Nursing Home placement! Yet it has been continually eroded by a lack of funds.

During January, 1982, IHS informed the program that its budget was being reduced 20%, retroactive to October 1, 1981.

The result of these cuts has been an increase in the Supervising Nurses' monthly travel for reservation visits. Telephone contact with field staff has been an essential component in dealing with emergency situations, this is no longer possible. Client contact with a professional nurse has been reduced from once every 2 weeks to once every 4 to 5 weeks.

Evaluation of client problems for early referral and treatmemt will certainly suffer. Reductions in our programs services come at a time when other agencies are also reducing their services. There are no other agencies to fill in the gaps, the services are simply lost.

Examples of services that will have to be eliminated or reduced include:

Interim clients
Meal deliveries
Transportation of Clients
Staff training
Many nursing services
Patient education
Routine monitoring
Preventive activities
Staff conferences
Referrals to other agencies

*Resource Requirement Methodology, average percent for all tribes

The program has strived very hard to expand its medical component. However, without properly trained staff the level of ability to care for chronically ill clients in their home will be drastically affected. If this type of care is unavailable, clients will need to be placed in extended care facilities, certainly a more expensive and less satisfactory solution. Although the Phoenix Area allocates over $1 million per year for Nursing Home costs, none of these dollars have come to Nevada!

Some personal examples of the types of services provided by the aides include:

A 50 year old male quadraplegic who is confined at home in his hospital bed. With daily visits from the aides he is bathed, given skin care to prevent bed sores, lifted into a wheelchair for a ride outside, fed his lunch, given his medication, repositioned back in bed, and his urine collection bag emptied. On monthly visits from the RN, his catheter is changed to assure proper drainage and prevent infection.

A 79 year old blind diabetic. The aide visits daily to draw his insulin into the syringe for him to administer himself.

An 80 year old male in chronic renal failure who requires twice weekly dialysis. Frequent visits by the aide for health and home care paid off in a life saving visit nearly a year ago when she found him hemorrhaging from the fistula in his arm. A tourniquet and a speedy trip to the hospital saved his life.

A 92 year old stroke victim who was not so fortunate. When the aide was on extended leave due to personal illness, this lady fell, fracturing a clavicle. Without the daily aide visits, she lay for 3 days undiscovered. What might have been a painful but relatively minor injury, required 2 weeks of hospitalization.

An 83 year old diabetic double amputee, living alone. Daily (sometimes 2 or 3 times daily) visits by the aides for complete care has kept her maintained in her home for 5 years. She is happy and healthy.

These are just few of the clients we serve. WITHOUT THIS PROGRAM, WHO WILL TAKE CARE OF THESE PEOPLE?

*Refer questions about the figures or statistics in this testimony to: Sharon Coleman, Research Analyst, Inter-Tribal 'ouncil of Nevada (702-786-3128 ext.211)

MAKAH TRIBAL COUNCIL
P.O. BOX 115 · NEAH BAY, WA. 98357 · 206-645-2205

February 23, 1982

Statement of Joseph A. Martin, Captain,

Makah Tribal Law Enforcement, Makah Tribal Council

MAKAH TRIBAL LAW ENFORCEMENT F.Y. 1983 BUDGET JUSTIFICATION

Mr. Chairman, once again the Makah Tribal Council has asked me to come before you to request the assistance of this Subcommittee in connection with the funding of our tribal law enforcement budget. The Makah Indian Reservation covers approximately 44 square miles on the extreme northwest corner of the Olympic Peninsula in the State of Washington. The Reservation is bounded by the Pacific Ocean to the west and the Strait of Juan de Fuca to the north. The Reservation terrain is isolated, rugged and mountainous and has miles of expansive beaches with spectacular scenery which annually attract more than 200,000 outsiders to the Reservation, especially in the summer months.

The Makah Indian Tribe has a tribal government organized pursuant to the Indian Reorganization Act of 1934, 25 U.S.C. §476. Shortly after federal organization in 1937 the Tribe adopted a law and order code and established a tribal court. Since this time the Tribe has consistently developed and now seeks to maintain an effective law enforcement program. With a view toward accomplishing this objective, the Tribe, in 1975, contracted with the Bureau of Indian Affairs under the Indian Self-Determination and Education Assistance Act to administer both law enforcement and correctional center manpower programs designed to improve the quality of Reservation law enforcement.

When we testified before this Subcommittee last year, our Police Department numbered nine officers and was able to provide around the clock law enforcement service throughout the Reservation. In view of a decrease in funding which became effective this year the Department was forced to cut back the number of officers to six, who still provide around the clock protection to life and property on the Reservation. This will be a particularly difficult task, especially during the months of April through September, during which time the population of the Reservation is nearly quadrupled by visitors to the Reservation, such as commercial and sports fishermen, campers, hikers and other tourists.

The Department provides a variety of services to non-residents of the community such as protection from vandalism of tourist vehicles which are left overnight on isolated reservation beaches and roads. The tribal police also engage in search and rescue operations to assist tourists when they are injured or lost in remote areas of the Reservation. As we noted in testimony before this Subcommittee last year, we have experienced a sudden increase in crime on the Reservation with respect to traffic in narcotics by organized crime.

We recently assisted in breaking up a highly sophisticated marijuana operation running contraband on the Reservation by seizing 290 bales of marijuana valued at nearly $50 million. We have been compelled, therefore, to allocate a large number of man-hours and fiscal resources to ensure an adequate level of drug surveillance.

The F.B.I. and the D.E.A. have confirmed the fact that organized crime is, indeed, managing and funding the smuggling of drugs within the Reservation and adjacent to the Reservation and we are hard put to match the resources which organized crime can muster to smuggle drugs through our Reservation. In addition to this specific problem we expect to encounter, as the BIA F.Y. 1983 budget request states, a general increase in crime. The BIA submission states:

> As economic conditions worsen on reservations the incidence of crime and alcohol abuse increases, requiring additional law enforcement activity.

In order to continue to provide adequate law enforcement services to the Reservation community, we need the assistance of this Subcommittee in restoring our law enforcement budget to the level of funding in F.Y. 1981 of $217,514. Our current base budget for F.Y. 1982 is $112,000, which is the result of a withdrawal by the BIA in F.Y. 1981 of $105,514 in IMPL funds which the Tribe had used to supplement the law enforcement program to ensure the provision of comprehensive services.

The Makah Tribe is not financially able to supplement these BIA funds which were unilaterally withdrawn. Consequently, the Tribe has been forced to reduce the number of officers to a bare minimum with no back-up for vacations or sick leave and will have to reduce the police vehicle fleet in the immediate future. The ability of the tribal police to detain prisoners and to despatch police assistance by radio will be significantly decreased in view of the anticipated forced reduction in correctional center staff. In short, the withdrawal of IMPL funds by the BIA, which the Tribe had previously used to accomplish these critical functions has jeopardized the lives and property of both the Makah Indian people and of the thousands of others who visit the Reservation each year.

The Makah Tribal Council has asked me to inform this Subcommittee that the law enforcement program is, indeed, one of the Tribe's highest funding priorities during this fiscal year and in F.Y. 1983. The importance of the law enforcement program will be reflected in the F.Y. 1983 BIA Band Analysis which the Tribe is amending now to designate law enforcement as a high priority. The Makah Tribe is requesting this Subcommittee, therefore, to assist in restoring the $105,514 in IMPL funds which was lost to the law enforcement program in F.Y. 1981 by honoring the following Senate appropriations report language:

> Within the funds provided through the IMPL transfer, the Committee expects that sufficient funds will be made available to the Makah Tribe for continuation of its law enforcement program.

Senate Report No. 97-166 at page 3.

We understand that the BIA directed that $658,560 be removed from the Olympic Agency IMPL Account in connection with the IMPL spend-out required by Congress in the F.Y. 1982 Interior Appropriation Act. This would leave a balance in the account of approximately $690,000 to remain available for supplementing existing programs which meet the approval of the BIA Superintendent. In accordance with the above report language, therefore, we are requesting that the Subcommittee earmark $105,514 within the remaining IMPL balance to immediately supplement the law enforcement program before September 30, 1982 when all such funds must be returned to the U.S. Treasury.

The Makah Tribal Police Department has provided outstanding law enforcement services to the Reservation community for several years and the Tribe feels that the ranking by the BIA of the program as the most efficient and well-organized police department in the BIA Olympic Agency area should not be overlooked by that Agency. Accordingly, we respectfully request that the House and Senate Appropriations Committees direct that the urgent funding needs of the Makah law enforcement program be met by specifying that the BIA Olympic Agency office shall restore immediately approximately $105,514 in IMPL funds withdrawn from the program in F.Y. 1981.

March 15, 1982

Statement

of

Donald Johnson, Chairman

Makah Tribal Council

On The F.Y. 1983 Budget of the Indian Health Service

Mr. Chairman, I am Donald Johnson, Chairman of the Makah Tribal Council and I am submitting this statement to request the assistance of your Subcommittee in maintaining the overall level of health care which has been provided by the Indian Health Service to the Makah Tribe. The Makah Indian Reservation covers approximately 44 square miles on the extreme northwest corner of the Olympic Peninsula in the State of Washington. Our reservation is isolated with extremely rugged terrain and we are located approximately 50 miles from the nearest hospital.

In view of this isolation, our tribe is heavily dependent on the health services which are provided by the Neah Bay Indian Health Service Clinic. We object to the extent to which this Administration has proposed decreases in major I.H.S. programs which we believe will result in a decline in the overall health of our people. First, the placement in June of 1981 of the Portland Area Contract Health Service Program on a "Priority One" service basis has resulted in a sharp decrease in the level of health care provided to our tribe.

Under the foregoing priority basis, health services are furnished to Indian people on an "emergency only" basis which results in a denial of preventive health services and a reduction in the level of health care for illnesses which are not critical. We believe that operating the contract Health Service program on this basis is inconsistent with a recent policy statement by the Secretary of Health and Human Services that the emphasis of the Department in F.Y. 1983 and at the present time will be on "wellness" and on preventive health and health promotion.

Our I.H.S. reservation clinic has also experienced severe difficulties in the last six months in obtaining drugs from the I.H.S. central warehouse in Portland, Oregon. During F.Y. 1981 we were able to obtain virtually all of the drugs necessary to stock the I.H.S. clinic adequately. During January of this year we were only able to obtain approximately 68 percent of the drugs needed to treat Indian patients on the reservation. We purchase approximately one-third of our drugs, therefore, on the open market to meet the health needs of our reservation patients. This shortage of drugs threatens the overall health of our people and is exceedingly costly to the government, since drugs purchased in the open market are priced higher. We request that the Subcommittee direct the Indian Health Service to remedy this drug shortage in the Portland Area immediately.

We strongly object to the proposal by the Administration to eliminate the $28,800,000 Community Health Representative program in F.Y. 1983. This program is managed and carried out by our tribe pursuant to a contract with the I.H.S. and includes five persons trained in emergency medical care and health care for the elderly on the reservation. Our C.H.R. personnel also provide transportation services to tribal members to urban hospitals to receive dialysis treatment and other kinds of therapeutic treatment which are not available on or adjacent to the reservation.

The elimination of the C.H.R. program would impose severe hardships on our tribe. For example, our ability to provide effective health crisis intervention service would be diminished sharply and our health service to the reservation elderly in their homes would be correspondingly reduced. We are barely managing to provide the foregoing services now in view of the fact that our C.H.R. contract has already been cut 17 percent during this fiscal year. We strongly urge, therefore, that your Subcommittee oppose the elimination of the C.H.R. program.

Finally, we note that the Department of Health and Human Services has not requested any funds in F.Y. 1983 for the construction of Indian health facilities, nor has it sufficiently increased the amount of funds requested for F.Y. 1983 for the maintenance and repair of existing health facilities. The proposed increase for maintenance and repair in F.Y. 1983 is $93,000 less than the $18,360,000 actually obligated in F.Y. 1981, and thus fails to provide for inflation and the deterioration of the facilities. The Neah Bay Indian Health Service clinic, in particular, needs extensive renovation and expansion of the emergency room area which might not be possible under the proposed F.Y. 1983 construction and maintenance budgets.

NAVAJO NATION HEALTH FOUNDATION

SAGE MEMORIAL HOSPITAL
POST OFFICE BOX 457 / GANADO, ARIZONA 86505 / (602) 755-3411

TESTIMONY FOR THE INDIAN HEALTH SERVICE BUDGET OVERSIGHT HEARINGS

February 15, 1982

Good morning, Senator DeConcini and staff members, I am Violet V. Smith of the Navajo Nation Health Foundation. On behalf of the Navajo Nation Health Foundation, the following comments are presented on the effects of the proposed budget cuts on the Foundation's health services to the American Indian and non-Indian residents of the south-central portion of the Navajo Reservation.

INTRODUCTION

The Navajo Nation Health Foundation (NNHF) is a private, nonprofit, nonsectarian organization which is providing health care services to the residents of Navajo Tribal District #17 and the Nazlini Chapter. However, our services are available to all who seek them, and patients are regularly seen from as far as Chambers, Indian Wells, Lukachukai, Rock Point, Houck, Fort Defiance and many other places on the Reservation.

The Foundation's services include both inpatient and outpatient care being provided at Sage Memorial Hospital in Ganado as well as community-managed clinics at Wide Ruins and Klagetoh; social services, and special clinics, such as a dental clinic, an eye care clinic, a mental health clinic, a well baby clinic, a prenatal/postpartum clinic, and periodic chest and heart clinics.

HISTORY

The NNHF is carrying on a 80-year tradition of health care to the Navajo people which began with the establishment of a Presbyterian mission hospital here in 1901. The original Sage Memorial Hospital was completed in 1930, and is still used today for administrative and certain medical purposes. In 1962, a new, modern, 45-bed hospital was built - the Sage Memorial Hospital that we know today.

The Presbyterians continued operation of Sage Memorial Hospital until 1969, at which time Project HOPE contracted with the Navajo Tribe and the Presbyterian Church to provide medical and administrative training to local Navajos. In July, 1974, the five year training period was completed and Project HOPE withdrew, leaving the responsibility for the hospital and other programs in the hands of the Navajo Nation Health Foundation. The Foundation carries the distinction of being the nation's first Native American managed health care organization. It is controlled by a Navajo Board of Directors, consisting of eight members elected by the local communities to represent the individual chapters within our service area, and seven additional members who are appointed for their special expertise in various areas related to medicine and administration. In addition to being Navajo managed, the NNHF promotes Indian Self-Determination through its staffing, which is now 79 percent Native American. Since December 20, 1977 it has been officially recognized and sanctioned by the Navajo Tribe as a P.L. 93-638, "Indian Self-Determination Act", organization.

ACCOMPLISHMENTS

New Programs

During the years that Project HOPE managed the hospital and health care programs they experienced operating deficits each year. When the NNHF assumed control, the Board tried to maintain the new programs started by Project HOPE, but without HOPE's financial reserves. The NNHF Board approved a $250,000 deficit budget for the first fiscal year (FY 1975), naively assuming that public and private grants would be available to the first Indian managed health care system. When funds did not become available the Foundation approached the Navajo Tribe for a loan to cover the deficit. There was great expectation for funding which was coming through Arizona State legislation to introduce Medicaid payments for indigents. The Medicaid bill was passed, but no funds were appropriated for it,* leaving the NNHF without the means to repay the loan. In recognition of the Foundation's problems, the Tribe graciously converted the $250,000 loan into an outright grant; nevertheless, we were still forced to make some serious budget cuts which resulted in the discontinuation of some programs and a reduction in services.

Subsequent to the first year, the NNHF has demonstrated continued growth, which has allowed a number of new and innovative programs to be put into operation. These include some programs which are unique to the Navajo Nation. The NNHF Personal Growth and Counselling Center is a community mental health program provideing counselling to patients at a full-time clinic in Ganado, and through home visits. Three therapists are assisted one day a week by a consultant psychiatrist from the IHS. The is currently the only non-IHS mental health program. The Center was established in 1978.

Home Health Worker (DDN) Services Beginning in 1970, home visits were initiated through the addition of Public Health Nurses and the use of DDN (indigenous home visitors). The home visitors and public health nurses were provided with radio communication to the base clinic stations (Ganado, Nazlini and Wide Ruins) from the 4-wheel drive vehicles.

During recent program cuts, no public health nurses have been employed and home visits have been continued by the Home Health Workers (2), which they have come to be called. As funding becomes available we hope to employ public health nurses again and reestablish the Home Health Care Team concept.

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* Arizona is the only State in which this occurred.

The NNHF Eye Care Program was established in August 1977, with funds made available through the Presbyterian Church, and has been in operation ever since as the only eye care program located in District 17. The eye care clinic is conducted periodically by the University of Arizona's Mobile Eye Care Unit and is primarily aimed at providing free services to the elderly and other needy Native American residents of the area. Glasses are provided without charge to those who cannot pay for them.

The NNHF Maternal and Child Health Care Program has been in operation for the past 5 years. The purpose of this program is to prevent many of the health problems that so often occur among young children and among women during and after pregnancy through regular physical check-ups and health education and family planning. At present these services are being provided at our Maternal and Child Health Care Clinic in Ganado, although our goal is eventually to provide such services in every community within our service area.

A Family Health Clinic has been serving the people of Wide Ruins since 1976, and a second clinic opened at Klagetoh in 1980. Both communities are actively involved in the operations of their clinics, each having elected a Health Advisory Committee which meets regularly with NNHF staff to represent the community viewpoint. A third clinic was opened at Ganado in 1981, emphasizing preventive and health maintenance services. We hope eventually to be able to establish similar clinics in all the chapters in our service area in order to make health care more accessible to the people we serve.

The Wide Ruins Clinic is Medicare-certified and was among the first in the Western United States to be so designated, an accomplishment we are quite proud of.

Prior to the funding shortages of the past year, services also included a public health nursing program, school health services, patient transportation services, health education services and ear-nose-throat clinics.

Since the birth of the NNHF, Sage Memorial Hospital, the "hub" of our health care program, has continued to carry on its long tradition of the highest quality health care. The hospital continues to receive the accreditation of the Joint Commission of Accreditation of Hospitals (JCAH). We have, since 1974 reinstated obstetrical services, added 3 new examining rooms in the outpatient department, expanded our inservice education programs, acquired a new ambulance and expanded and housed our laboratory in a larger, separate facility. Our medical staff has increased to six physicians, two nurse practitioners, two physicians assistants and two dentists, increasing our capability of providing care to steadily increasing numbers of patients.

VOLUME OF SERVICES

Since its inception, the Foundation has seen a steady increase in the volume of its services, as reflected in the number of patient visits. The greatest increase has occurred in Community (non-hospital based) health services, since this is the area we have emphasized in an attempt to stress prevention, address special problems and high risk groups and make health care more accessible to the people.

	1976	1977	1978	1979	1980	1981
SMH INPATIENT (admissions)	1,091	1,050	1,211	1,048	1,151	1,337
SMH OUTPATIENT VISITS	15,998	18,979	21,734	21,687	22,231	22,802
COMMUNITY HEALTH SERVICES: Total * Patient Encounters	4,778	6,564	6,859	9,248	19,361	16,659

* Includes MCHC, Outreach Clinics, Public Health Nursing, Mental Health, Dental Clinic and Home visits (included in 1980/CHS figure only)
and 1981

WHAT THE NNHF HOPES TO ACCOMPLISH

The NNHF has the distinction of being the first non-governmental Native American managed community based health care organization which provides an array of services, from inpatient medicine to community based outpatient and outreach services. Our goal is to strengthen and broaden this role as an Indian Self-Determination Organization. If the necessary funding can be obtained, we will achieve this goal through the following measures;

1. Achieving financial autonomy through gaining direct adequate Federal funding.
2. Providing the full range of needed health and health related services to all residents of District 17, including inpatient services, hospital outpatient services, public health nursing, an outreach clinic in each major community we serve which provides primary care as well as preventive services (MCHC, blood pressure screening, etc.), school health services to all schools in District 17, eye care services, emergency services, patient transportation, mental health services, dental services, and hearing services. These services shall be readily accessible, of high quality, culturally acceptable, and cost effective.
3. Expanding the capabilities of the Native American community to operate and manage the NNHF and its programs through educational programs for the Board of Directors, training of local residents as health care workers, establishment of a health committee in each chapter we serve, and training of Navajo employees to assume the top management positions of the NNHF.

FINANCIAL CONSIDERATION

Since the initial setbacks and the aid from the Navajo Tribe in 1975, the financial situation has shown steady improvement, although the Indian Health Service reimbursement has not kept pace with expanding services. The NNHF continues to operate very efficiently; we most definitely get "the most for our money". This is reflected, for example, by the fact that we have held our administrative expenses to the absolute minimum so that maximal dollars could be expended on actual services (i.e., direct patient care and support):

	F.Y. 1976	1977	1978	1979	1980
DIRECT PATIENT CARE SERVICES	57.7%	59.3%	61.8%	63.0%	68.9%
SUPPORT SERVICES	37.9%	34.6%	28.3%	25.7%	21.6%
ADMINISTRATION/ FUNDRAISING	4.4%	6.1%	9.9%	11.3%	9.5%

Percentage of total expenditures devoted to direct patient care, support services, and administration.

From NNHF annual Fiscal Statements with auditors Report for Fiscal Year 1976, 1977, 1978, 1979 and 1980.

NOTE: "Direct Patient Care Services" includes nursing services, outpatient services, other professional services (pharmacy, dietary, lab., x-ray, medical records, dental, social services, community health services, etc.).

"Support services" includes housing, housekeeping, maintenance, transportation, fiscal services, utilities, telephone, etc.

"Administration" includes Board of Directors, executive offices, personnel, public relations, and fundraising.

FUNDING

The NNHF derives the majority of its monies from a health service contract with the Indian Health Service. We have not, however, relied solely on this source, but have actively sought funding from other sources. We have received small grants from several private foundations; a Rural Health Initiative Grant from D.H.E.W. (now expired), contract monies from the Arizona Department of Health Services; modest reimbursement from patients, private insurance, and Medicare; and private donations.

A private donor fundraising campaign was launched 2½ years ago, which has become increasingly successful. In 1981, the campaign netted $108,000. However, we project that it will be another 2 to 3 years before this program contributes substantially to the operating capital for the Foundation. A sustained effort is being made to obtain long term grants from private foundations.

CURRENT FISCAL DIFFICULTIES

The current fiscal difficulties of NNHF stem mainly from the fact that the Indian Health Service has never fully reimbursed us for services rendered to its beneficiaries. As a result, NNHF has had to absorb costs with funds which should have been used to accumulate a reserve for replacement and repair as well as to avoid carry over of deficits. This has created a deficit situation, which is very difficult, if not impossible, to get away from. What is responsible for this deficit? Our contract with the Indian Health Service pays a certain sum of money to cover each patient visit/encounter which covers all the various services (physician services, pahrmaceuticals, laboratory tests) rendered. However, the contract has an annual ceiling above which no reimbursement is given, regardless of how far the costs of patient services exceed it. This ceiling is unrealistically low. The result of this is that for the past several years we have been forced to provide theequivalent of two months worth of health care services free, and have had to absorb the losses as shown on the following table (dental services not included):

	F.Y. 1978	1979	1980	1981
BILLED TO IHS ($)	1,530,845	1,610,780	1,676,818	*
IHS CONTRACT CEILING ($)	1,341,600	1,432,800	1,575,000	1,621,000
BALANCE CARRIED BY NNHF ($)	189,245	177,980	101,818	over (200,000)

* Precise figures for F.Y. 1981 are awaiting auditor confirmation, but it is clear that over the past four years the IHS has failed to reimburse us for over $600,000 worth of medical care rendered to its beneficiaries. A comparable situation has developed in regard to our dental services contracts.

Reasonable estimates of services to be provided in F.Y. 1982, and reasonable cost figures for providing these services, indicate that Medical and Dental Services contracts with the Indian Health Service should total $2,241,082. However, the contract ceiling offered for F.Y. 1982 is only $1,650,080, a difference of $591,002.

The NNHF can not survive on its present contract funding, let alone realize its goal of becoming a truly community-based Native American managed comprehensive health care system. We must receive full reimbursement for the services we provide.

We therefore respectfully request the support of this Committee in obtaining federal funding of $2,241,082 for our services to Native Americans in fiscal year 1982, either by means of a direct appropriation, or through an increase of $591,002 in the contract ceiling offered by the Indian Health Service.

The Navajo Nation Health Foundation is a successful Indian Self-Determination Organization, and it expects the United States Government to support, not discourage, this status under P.L. 93-638.

Thank you for your thoughtful attention to our concern.

RESOLUTION OF THE BOARD OF DIRECTORS OF THE NAVAJO NATION HEALTH FOUNDATION

Requesting the Action of the Director of the Indian Health Service and the Congress of the United States in Adding $591,002 to the Indian Health Service Medical and Dental Service Contracts with the Navajo Nation Health Foundation for Fiscal Year 1982.

WHEREAS:

1. The United States Government, through its Indian Health Service is responsible for health care of Native Americans; and

2. The Navajo Nation Health Foundation, founded in 1974, is a comprehensive health care program governed by Navajos, has been sanctioned by the Navajo Tribal Council as a P.L. 93-638 organization, has received support from the Tribal Council, and works cooperatively with the Navajo Division of Health Improvement Services; and

3. The Navajo Nation Health Foundation, with its Sage Memorial Hospital, outpatient department, dental clinic, satellite clinics, and variety of other programs, is the only health care organization for a large geographic area of the Navajo Reservation, and provides essential services to the approximately 12,000 residents of this area; and

4. As a private non-profit health care corporation, the Navajo Nation Health Foundation is governed by the laws of the State of Arizona, and is required to provide services to all who come, regardless of ability to pay; and

5. The Navajo Nation Health Foundation is dependent on a contract with the Indian Health Service to provide these essential services; and

6. The contracts with the Indian Health Service for fiscal year 1981 fell short of the cost of providing services by over $200,000, leaving the Navajo Nation Health Foundation with a deficit of this amount; and

7. Reliable estimates of services to be provided in fiscal year 1982, and reasonable cost figures for providing these services, indicate that Medical and Dental Services contracts with the Indian Health Service should total $2,241,082; and

8. These contracts as offered by the Navajo Area Office of the Indian Health Service only total $1,650,080; and

9. The Navajo Nation Health Foundation will be forced to discontinue many essential services, or even close its doors, if limited to the offered contract.

NOW THEREFORE BE IT RESOLVED THAT:

The Board of Directors of the Navajo Nation Health Foundation hereby respectfully requests action by the Director of the Indian Health Service, and, if necessary, the Congress of the United States, to add $591,002 to the Fiscal Year 1982 Medical and Dental Services contracts offered by the Indian Health Service.

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Board of Directors of the Navajo Nation Health Foundation at a duly called meeting on January 28, 1982, in Ganado, Arizona, at which a quorum was present and same was passed by a vote of 10 in favor and 0 opposed.

Violet V. Smith

Violet V. Smith, Chairperson
Board of Directors
NAVAJO NATION HEALTH FOUNDATION

Nez Perce
TRIBAL EXECUTIVE COMMITTEE
[redacted] (208) 843-2253

Statement of Walter Moffett,
Member, Nez Perce Tribal Executive Committee
on the F.Y. 1983 Bureau of Indian Affairs and
Indian Health Service Budgets

February 24, 1982

Mr. Chairman and Members of the Committee, my name is Walter Moffett. I am pleased to have the opportunity to present to you comments and recommentations on the F.Y. 1983 Bureau of Indian Affairs and Indian Health Service budgets on behalf of the Nez Perce Tribe of Idaho. I am a member of the governing board of the Nez Perce Tribe.

We would like to bring to your attention the severe hardships which would be experienced by members of our Tribe as a result of budget cuts proposed by this Administration. These are of great concern not only to our Tribe but to all Indian tribes across our great nation.

As a Tribe we have fully supported the efforts of previous administrations to promote economy and efficiency in government. The proposed F.Y. 1983 budgets of the BIA and the IHS will not accomplish the goals of this Administration without inflicting severe hardship on people in a number of programs which are operated for the benefit of Indians; such as higher education, scholarships and adult education in the BIA budget and direct health care services and the Community Health Representative (CHR) program (which is to be eliminated) in the F.Y. 1983 budget of the IHS.

The Executive Committee of the Nez Perce Tribe is very disturbed about the BIA and IHS budgets which propose the elimination or significant reductions in vital services to our people. Our great leader, Chief Joseph, once said: "I have heard talk and talk but nothing is done ... good words will not bring my people good health. I am tired of talk that comes to nothing." Your colleague, Senator Henry Jackson, stated in 1974: "... health services must be the cornerstone upon which rests all other federal programs for the benefit of the Indians."

I am sure that the members of this Committee are well aware of the fact that for several years, the United States Government has established goals for improving the health of the Indian people to the "highest possible level." Section 2 of Public Law 94-437, the Indian Health Care Improvement Act, states

> ... a major national goal of the United States is to provide the quantity and quality of health service which will promote the health status of Indians to be raised to the higher pos-

sible level and to encourage the maximum participation of Indians in the planning and management of those services.

Since the establishment of this goal we have not witnessed any clear plan of implementation. We have experienced, on the other hand, severe reductions in almost all categories of health services. As this Subcommittee knows, the provision of health services to Indian people is the responsibility of the federal government through the Public Health Service and the Indian Health Service. This responsibility has been confirmed repeatedly by Congress through legislation as well as through the courts.

The Northern Idaho Health Clinic located at our tribal headquarters in Lapwai, Idaho, is a multi-jurisdictional agency, serving the Nez Perce, Coeur d'Alene and Kootenai tribes, with a total population of approximately 2,200 people living on or near the reservations. Approximately 9,700 Indians received out-patient services through the IHS system in F.Y. 1980 and 10,667 in F.Y. 1981. The total number of out-patients at the clinic was approximately 11,000 -- an increase of about ten percent. The increase in out-patient service is due to the impact of the IHS budget cuts of June 1981 when the Portland Area Contract Health Service program was placed on Restricted Priority No. 1 (urgent and emergency care only). The Portland area, like other areas, continues to be managed on a Priority One basis. Since the Portland area has no IHS hospital and in view of the fact that the Seattle Public Health Service hospital was closed, there are only limited clinical facilities available to Indians and the IHS must purchase private sector health care and hospital services through contract health service programs. The proposed contract health service budget - in view of the services which must be furnished - provides only a marginal increase which would not keep pace with similar increases provided in the private sector for medical and hospital care.

Another concern which compounds the problems of the already limited budget for contract health service is the continued expansion of the service population. This is caused not by our choice but by the extension of eligibility by the Indian Health Service to non-Indian spouses for provision of service. This extension of eligibility decreases the budget for direct patient care which is critically needed by our tribal members.

In addition, previously non-federally recognized tribes have now been extended eligibility and no supplemental IHS funds for direct patient care and other IHS services were included in an already depleted budget.

We recommend that the IHS budget for F.Y. 1983 be provided with the funds necessary to implement and fulfill the goal of Congress and the Nation of providing the highest possible level of health care to Indians and the provision of adequate funds for the existing service population.

Moreover, in abolishing the Community Health Representative (CHR) program, the Administration is recommending the termination of what we consider to be a mainstay of our tribal health program and of many other tribal health programs as well. The Community Health Representatives provide general and specialized care to tribal members throughout the reservations and in some cases, in remote areas where transportation is non-existent. These persons provide a number of health-related services to Indians of all ages, including home health care, emergency medical service, health education, dental care, maternal and child health care, nursing and care for the elderly, who in many cases cannot speak English. We are of the opinion that the C.H.R. program is one which has successfully implemented Indian self-determination. Most tribes have responded enthusiastically to contracting the C.H.R. program under P.L. 93-638 in view of an obvious lack of accessible and acceptable health care to our tribal members on or near the reservation. The C.H.R. program has come a long way in the brief ten years of its existence and has proven to be an effective program. Wherever tribes are more traditional, the C.H.R. program embraces traditional modes of Indian health care which have been successfully integrated into a comprehensive health service network. All tribes have a desire to see this holistic approach to the Indian community health needs expanded toward a healthier future for all our people. Therefore we recommend that the Community Health Representative program be restored to the IHS F.Y. 1983 budget.

We also recommend that funding for construction of Indian health facilities be restored to the IHS F.Y. 1983 budget. I am attaching a resolution adopted by the Executive Committee on January 16, 1979, requesting that the Northern Idaho I.H.S. Clinic be expanded. Currently, there is furniture in the hallways with very little space available at the Clinic to provide privacy for patients.

I will be submitting a supplemental statement on the critical issue of Indian Education in the F.Y. 1983 budget of the Bureau of Indian Affairs.

Attachment

NP 79-171

RECEIVED
JAN 18 1979
NORTHERN IDAHO AGENCY

RESOLUTION

WHEREAS, the Nez Perce Tribal Executive Committee has been empowered to act for and in behalf of the Nez Perce Tribe, pursuant to the Revised Constitution and By-Laws, adopted by the General Council of the Nez Perce Tribe, on May 6, 1961 and approved by the Acting Commissioner of Indian Affairs on June 27, 1961; and

WHEREAS, THE NEZ PERCE TRIBAL EXECUTIVE COMMITTEE DOES CONSIDER THE EXISTING HEALTH FACILITIES OF THE INDIAN HEALTH CENTER (LAPWAI) ARE INADEQUATE; AND

WHEREAS, THE EXISTING HEALTH FACILITIES OF THE INDIAN HEALTH CENTER (LAPWAI) ARE INADEQUATE DUE TO THE LACK OF SPACE FOR PRESENT AND FUTURE HEALTH PROGRAMS, AND ACCORDING TO THE RESOURCE ALLOCATION CRITERIA, (RAC) NORTHERN IDAHO INDIAN HEALTH SERVICE UNIT IS PRESENTLY STAFFED AT 46%, AND LACK OF SPACE SEVERELY INHIBITS FUTURE STAFF INCREASES; AND

WHEREAS, THE EXISTING HEALTH FACILITIES ARE INADEQUATE DUE TO POOR TRAFFIC PATTERNS WHICH CAUSES INCONVENIENCE TO BOTH INCOMING PATIENTS AND STAFF; AND

WHEREAS, THE HEALTH EQUIPMENT IS CONSIDERED INADEQUATE AND OUTDATED TO HANDLE PRESENT AND FUTURE PATIENT WORKLOADS.

NOW, THEREFORE, BE IT RESOLVED, THAT THE NEZ PERCE TRIBAL EXECUTIVE COMMITTEE DOES HEREBY REQUEST THE SUPPORT AND ENDORSEMENT IN SEEKING THE FUNDING FOR A NEW AND LARGER INDIAN HEALTH CENTER TO BE LOCATED AT LAPWAI, IDAHO, AND THAT PROFESSIONAL AND SUPPORT STAFF BE INCREASED 54% TO MEET THE INDIAN HEALTH NEEDS; AND

BE IT FURTHER RESOLVED, THAT FEDERAL AGENCIES SUCH AS THE U.S. DEPARTMENT OF COMMERCE ECONOMIC DEVELOPMENT ADMINISTRATION THE PORTLAND AREA INDIAN HEALTH SERVICE, AND SENATORS CHURCH AND MCCLURE BE CONTACTED TO SEEK THE NECESSARY FUNDS FOR THE NEW AND LARGER INDIAN HEALTH CENTER TO BE LOCATED AT LAPWAI, IDAHO.

CERTIFICATION

THE FOREGOING RESOLUTION WAS DULY ADOPTED BY THE NEZ PERCE TRIBAL EXECUTIVE COMMITTEE MEETING IN SPECIAL SESSION JANUARY 16, 17, 1979, IN THE TRIBAL CONFERENCE ROOM, LAPWAI, IDAHO, A QUORUM OF ITS MEMBERS BEING PRESENT AND VOTING.

BY:
ASSISTANT SECRETARY, NPTEC

ATTEST:

CHAIRMAN, NPTEC

NOTED:

Superintendent, Northern Idaho Agency
January 26, 1979

STATEMENT OF WALTER MOFFET

NEZ PERCE TRIBAL EXECUTIVE COMMITTEE ON THE PROPOSED INDIAN EDUCATION BUDGET FOR F.Y. 1983

Mr. Chairman, I am Walter Moffet and I am a member of the Nez Perce Tribal Executive Committee. I am submitting these remarks on Indian education in accordance with testimony which I presented to your Subcommittee last month. I wish to bring to the attention of the Subcommittee in this statement the extent to which the quality of Indian education on our reservation will suffer as a result of budget cuts proposed for F.Y. 1983 by this Administration.

Mr. Chairman, the efforts of the public school system to adequately educate our Indian children have failed tragically to date. For example we estimate that approximately 50 percent of our tribal students in the public school system "drop out" prior to reaching the level of 12th grade in high school. The Nez Perce Tribal School was established in order to remedy this situation and to create an environment in which our tribal students could receive an education from the standpoint of their own cultural perspective and tradition. Our tribal school, which remains in an embryonic stage of growth, is having a very positive impact with respect to the education of our tribal children.

We feel that the Bureau of Indian Affairs F.Y. 1983 proposed budget for Indian education significantly undermines the progress our tribal school has made by recommending funding decreases or eliminations in critical program areas. For example, we object to the proposal of the Bureau of Indian Affairs to fund the Johnson O'Malley program at the existing F.Y. 1982 level of $25,954,000. The Bureau has justified not increasing the funding of this program in view of the fact that tribal contract schools such as ours will no longer be receiving Johnson O'Malley funding thus decreasing the number of students served. We would like to stress to this Subcommittee the fact that our tribal school has been using funds derived from the Johnson O'Malley program to provide cultural programs in Nez Perce language, history and culture to our children.

These courses of instruction, which are a source of cultural enrichment and pride to our children, will be sorely missed in F.Y. 1983 if the Bureau is permitted to withhold Johnson O'Malley funding from our tribal contract school in accordance with its budget submission. We also object to the proposal by the Bureau in F.Y. 1983 to cut the School Board training fund by $400,000 from a F.Y. 1982 level of funding of $960,000. We do not feel that our tribal school board should have to forego essential training in connection with the operation of the tribal school simply because the Bureau's Central Office requires budgetary cutbacks at the tribal level so that Bureau of Indian Affairs administrative positions will be secure.

We would also like to express our concern to the Subcommittee with respect to the proposed transfer of the Title IV Indian Education Act program from the Department of Education to the Bureau of Indian Affairs in F.Y. 1983 upon the termination of the Department of Education. We fear that the Bureau, whose education philosophy and programs are modeled on a "public School" concept may not be able to adequately manage the culturally innovative programs which the Department of Education has administered for the benefit of Indian children. On behalf of the Nez Perce Tribal Executive Committee, I would like to thank this Subcommittee for considering our comments and recommendations.

PASCUA
YAQUI
TRIBE

4821 WEST CALLE VICAM — TUCSON, ARIZONA 85706 — PHONES (602) 883-2838 & 883-2839

TESTIMONY SUBMITTED FOR THE RECORD,
SENATE SELECT COMMITTEE ON INDIAN AFFAIRS,
OVERSIGHT HEARINGS,
PHOENIX, ARIZONA
FEBRUARY 15, 1982

The Pascua Yaqui Tribe became a federally recognized tribe in September 1978. The Tribe has approximately 5500 enrolled members residing within the State of Arizona. Approximately 3500 Yaquis live in Pima County and receive health services from the Tucson Service Area Office (Office of Research and Development) of Indian Health Service. The New Pascua Reservation, located 15 miles southwest of Tucson, contains 147 homes and a population of 1000 plus Yaquis. Old Pascua, located in north Tucson, consists of an enrolled population of 547 Yaquis. Yoem Pueblo in Marana, 35 miles west of New Pascua, is a rural community with a population of 183 Yaquis. Approximately 2000 Yaquis live outside Pima County. Most are located in Guadalupe, 10 miles south of Phoenix, with small community groups in Scottsdale and Eloy as well.

The health status of Yaquis is significantly lower than that of the general population. The major causes of mortality are cardiovascular disease, accidents and alcohol related illness. The major causes of morbidity are diabetes, other chronic conditions, such as kidney disease, cirrhosis, and respiratory illness. The Yaqui population in Pima County requires hospitalization twice as often as the general population. There are 840 hospital days per thousand versus the national average of 450 hospital days per year. The average length of hospital stay is approximately 7 days versus the norm of 6.5 days.

The birth rate among Yaquis is 3 times that of the general population. Twenty-five per cent of all births in 1981 were premature. Two infants out of every fifty births can be expected to have severe health problems as a result of premature birth, poor prenatal care or poor nutritional status of the mother. There is a high rate of teenage pregnancy among Yaqui girls.

Approximately 3500 tribally enrolled Yaquis reside in Pima County and receive Contract Health Services (CHS) from the Tucson Area Office (ORD). At the time the Tribe was recognized it was determined that neither San Xavier Clinic nor Sells Hospital, both located on the Papago Reservation, were able to assimilate the additional load which would be placed on these facilities by Yaqui patients with extensive unmet health needs. The San Xavier Clinic is 8 miles from New Pascua, 45 miles from Marana and 13 miles from Old Pascua. Sells Hospital is approximately 60 miles from Tucson.

IHS and the Tribe agreed that a request for additional facilities would result in substantial and unacceptable delay in accessing health care. IHS, therefore, contracted with El Rio Santa Cruz Neighborhood Health Center (El Rio), in metropolitan Tucson, to provide Health Maintenance Organization (HMO) coverage through a prepaid capitation rate plan. This is the first and only prepaid HMO plan provided for an Indian group. It represents a unique and innovative approach by IHS to meeting the health care needs of Indian people. Potential total El Rio enrollment by 1983 will be 3300 patients. Enrollment is currently at 2800 patients with monthly additions of 30 persons including new births and new registrations.

In 1982, shortages of CHS funds for the El Rio contract have resulted in the removal of a number of benefits from the HMO plan. A 10% reduction in CHS resulted in the removal of the following services:

1. Skilled Nursing Home Care
2. Inpatient and Outpatient Physical Therapy
3. All Mental Health and Substance Abuse Services

4. Oral Surgery
5. Out of State Coverage
6. Physician Home Visits
7. Renal Dialysis

There will still be a $160,000 shortfall which will result in the termination of all El Rio services during August and September of 1982 unless additional funds are made available. No alternative IHS resources are presently available to meet the health needs of the 2800 Yaquis currently served by El Rio. Substantial new staff and renovation would be needed to accomodate Yaquis at San Xavier Clinic which provides limited direct ambulatory care services to the Papago Tribe. This facility is presently utilized at capacity by the existing Papago patient load.

Contract Dental Services have been reduced by 50% as a result of the budget reductions. Funds were reduced from $126,043 in 1981 to $65,000 in 1982. Dental Services presently exclude dentures, crowns, bridges, orthodontia and oral surgery although an estimated 200 patients will require these dental care services in 1982. Dental care is available only three weeks per month as a result of funding shortages.

The Pima County Medical Assistance Program does not have adequate funds or staff in its 1982 budget to provide for the imminent service demands of the Yaquis and the Papagos in Pima County as a result of CHS shortages. The estimated cost to the county for the five Yaqui nursing home and dialysis patients, eighteen Papago nursing home patients and eighteen Papago dialysis patients that they have accepted will be in excess of $500,000 per annum. No Medicaid relief will be forthcoming until March of 1983. There are presently no direct care Indian nursing home facilities or renal dialysis facilities in Southern Arizona.

Tribal Health Programs

The Yaqui Tribe has contracted with IHS to provide Public Health, CHR and Prevention Services since 1980. There are no service units or field services provided by IHS to Yaquis. 1981 contracts in the total amount of approximately $360,000 were awarded to support a staff of 13 including 2 public health nurses, 4 CHR's and an Environmental Health Technician. Programs included:

(1) public health and home health nursing
(2) health education
(3) sanitation
(4) program planning and evaluation
(5) transportation
(6) outreach
(7) eyeglass and hearing aid procurement
(8) health administration activities
(9) El Rio Contract monitoring and evaluation
(10) Medical Social Service

Over 50% of the Yaqui contracts were funded with "non-recurring" IHS monies. The balance of funds, $177,555, were in the 1981 base. ORD received no non-recurring funds to maintain Yaqui contracts in 1982. 1982 cutbacks, amounting to approximately 20% applied to the base 1981 figure, have resulted in an actual cutback in "638" contract funds of more than sixty-five per cent.

The Tribe anticipated financial reductions in 1982 and, therefore, in 1981 the following planned activities were deleted from tHe FY 1981 Contract program to save carry-over funds for FY 1982:

(1) Clinic Feasibility Study
(2) Emergency Medical Services Study
(3) Transportation Study
(4) Tribal Healer Study
(5) Nutrition Assessment
(6) Health Needs Survey and Assessment
(7) Health Education Needs Assessment

All of the above studies were essential to the development of an accurate long-range Tribal Specific Health Plan (TSHP). Study funds are needed to complete the critical assessment activities required to devclop a functional and realistic TSHP for the Yaqui Tribe.

There are many unmet health needs for which no funds or personnel are available. These needs include among others:

(1) Mental health services
(2) Substance abuse treatment and prevention
(3) Nutrition and health education
(4) Air quality and environmental health services
(5) Chronic disease programs

Cutbacks in 1982 Health Department funds affect approximately 2000 Yaquis residing in Pima County and receiving services from the Health Department. The Health Department staff has been reduced as follows:

1. Public Health Nursing - Reduction of 50% of staff has resulted in the termination of prenatal nursing education program, 50% reduction in home health care, total termination of in-service and staff education and community health education.

2. Community Health Representatives - Reduction of CHR staff from 4 CHR's and 1 van driver to 2 CHR's and 1 van driver and loss of 3 GSA vehicles has reduced the time available to CHR's for outreach and education activities. The CHR's have a current caseload of 1350 patients per CHR and are responsible for coverage of Pima County(6 million square acres) Outreach service to Marana and Old Pascua have been reduced by 75% affecting 1000 patients. No training funds are available. Additional cuts in CHR funds have been proposed by ORD.

3. Environmental Health Services (EHS) - One generalist CHR provides EHS to the New Pascua population estimated at 1000 persons. No services are provided to to any other communities due to shortages of staff. The EHS technician remains untrained in EHS due to lack of training funds. Funds and staff are unavailable to evaluate the environmental factors which may have contributed to the high incidence of respiratory illness and hospitalization among Yaquis in 1981.

4. Therapeutic Recreation - In 1981 the Recreation Program provided services to 50 teenagers, 100 senior citizens and 100-150 school age children at New Pascua. These activities resulted in 8200 participant hours and included:

(1) Teenage Game Room
(2) Sports (baseball, swimming, etc.)
(3) Senior Citizen Recreation and Exercise Programs
(4) Adult Aerobic Exercise
(5) School Age Recreation (arts, crafts, Yaqui cultural arts, exposure to Tucson Community cultural and educational resources)
(6) Summer Activities Program
(7) After School Recreation

Services were provided by 2 recreation specialists and 8 part-time activities workers. All recreation staff have been laid off. No recreation activities funds are available to Yaquis in 1982 through the IHS or BIA.

Approximately 500 children need, and are not receiving, experience in constructive alternatives to the growing subculture which pressures children to participate in harmful and self-destructive lifestyles.

5. Health Administration and Planning - Currently, funds are available to maintain administrative functions until May, 1982. All planning functions have been redirected to attempts to maintain Health Department services at 35% funding levels and ameliorate the impact on the service population. Health administration activities are focused on planning for the loss of all CHS in August and September, 1982 and investigation of potential alternatives including San Xavier, Medicaid and Pima County.

The Health Department Eyeglass and Hearing Aid Program, initiated in 1980-81 in Pima County has been reduced by 33 % from $18,000 in FY 1981 to $12,000 in FY 1982. The Health Department will exhaust all funds for purchases of vision and hearing appliances by May 1, 1982. The estimated unmet need for vision and hearing appliances is in excess of 300 individuals for 1982 excluding the need for new prescriptions and frames for current clients.

The Pascua Yaqui Tribe and IHS have made considerable effort in the past three years to identify unmet health needs and develop programs to meet some of those needs. Over a two year period the IHS, Health Department and El Rio Plan have addressed the priorities identified in the 1979 TSHP. The FY 1981 Health Department Program and CHS Program were at a developmental rather than ongoing level. Therefore, no "fat" existed in the budgeted funds. Reductions of 65% and 10% respectively have resulted in the reduction and/or termination of essential rather than luxury program activities in Pima County.

IHS Services to Yaquis in Phoenix Service Area

Virtually no health service is provided to 2000 Yaquis outside Pima County with the exception of Phoenix Indian Medical Center (PIMC) in Phoenix, Arizona. Yaquis residing outside Pima County receive no contract health care (CHS) or Community Health Representative (CHR) services. No public transportation is available to access PIMC. Rarely are beds available to Yaqui patients. There is no priority admission system for Yaqui Indians not eligible for CHS but rather admissions are based on a "first come, first serve" philosophy. Yaquis have been refused services at many IHS hospitals and clinic facilities statewide on the basis that no beds are available or that the clinic is unable to accept new patients. No funds have been made available to the Phoenix Area Office to provide for the care of eligible Yaqui patients.

Their health needs remain unmet in spite of eligiblity within the IHS direct care system.

Summary Statement

Within Pima County, the implementation of IHS programs, and the efficient and innovative use of federal funds by ORD and the Tribe, has resulted in the development of what we believe to be a model program of outstanding potential and current accomplishment. The blending of the HMO concept with a strong tribally operated community based Health Department can provide a more cost-effective alternative to selected tribes than the piecemeal CHS approach utilized elsewhere for Indian populations. The cost of HMO coverage increased by only 5% in 1982 while the general rate of health services inflation has reached the double digit level. The El Rio HMO contract for 1982 has been negotiated for 5 months (March - July, 1982). Unless additional funds are allocated to Yaqui CHS the prepaid HMO plan will terminate in July, 1982 without a reliable alternative source of care for non-life threatening illnesses.

The actual cutbacks in tribal health programs already experienced from October, 1981 - February, 1982, have resulted in a 50% reduction in staff and services. The projected cutbacks for the balance of FY 1982 will result in the dissolution of the Pascua Yaqui Health Department by June, 1982. The Tribe is currently discussing the process of retrocession of its two "638" health contracts with IHS personnel. IHS has advised the Tribe that no additional funds or staff will be available if in fact the Tribe formally requests retrocession.

Recommendations for Corrective Actions

1. The El Rio HMO was implemented as an exploratory demonstration project to determine if HMO alternatives can reduce the cost of Indian Health Care. One and one half years of operating data (1980-81) are available. Continuation of contract operation in FY 1982 and 1983 would provide a solid statistical base for analysis of the cost-effectiveness of the HMO alternative. Therefore, the Pascua Yaqui Tribe requests a supplemental appropriation for FY 1982 and a line item appropriation for FY 1983 for the El Rio Santa Cruz Neighborhood Health Center to fund CHS and associated items, from October, 1981 through September, 1983.

   Total CHS (El Rio) Funds Required *

   Supplemental Appropriation for FY 1982 = $170,446

   Line Item Appropriation for FY 1983 = $2,105,784

   * Financial data provided by ORD, Tucson, Arizona based upon current Headquarters allocation to the Tucson Area Office

2. The CHR Program is more than an Indian transportation system. Most tribes, including the Pascua Yaqui Tribe, utilize CHR's for home based health services, prevention and education in order to reduce the cost of acute and institutional care. The Tribe requests reinstatement of CHR funds nationally at the FY 1981 level.

   If this is not feasible the Tribe requests that Congress re-affirm its directive to IHS regarding how cutbacks will be apportioned. Congress mandated that CHR reductions be based on the following considerations:

   (1) areas where new facilities have been constructed
   (2) areas with high concentrations of health providers
   (3) evaluation of the quality of the CHR Programs

   Headquarters thus far appears to have directed Area Offices to apply reductions in CHR funds in a non-selective, accross the board cutback of all CHR Programs by approximatelt 21%. This is in direct opposition to the instructions of the Congress.

3. The Tribe requests that the tribal health service base for the Pascua Yaqui Tribe be raised from $177,555 to $300,000 for FY 1982. The FY 1981 base was allocated to the Tribe based on projected enrollments of 1,000 Yaquis in FY 79-80. This estimate was totally inaccurate. The actual enrollment is 5,500 with over 3,000 enrolled Yaquis residing in Pima County.

4. The Tribe requests that a separate allocation of funds be placed in the FY 1982 base for the Phoenix Area Office to provide limited CHR and transportation services to Yaquis living in the Phoenix area. Such services are being provided to other tribes at this time. These services would assist over 1300 Yaquis in accessing existing IHS services for which they are eligible at minimal cost.

5. The Tribe would also like to bring to the Senator's attention the Indian Self-Determination Memorandum Number 81-5 (attached) dealing with IHS negotiation of P.L. 93-638 contracts. The implementation of this memorandum and the subsequent financial risk to the tribal contractor will make it virtually impossible for tribes to request additional transfers of programs using the "638" contract

mechanism without assuming prohibitive risks.

It would be difficult indeed to ask a space shuttle astronaut to volunteer for a one way trip to the moon with the return voyage subject to the later availability of funds. This, in essense is the risk a Tribe will assume in future "638" contracts. Should this policy be implemented the Pascua Yaqui Tribe believes that a death blow will be dealt to the principle of self-determination as expounded in P.L. 93-638.

The Pascua Yaqui Tribe urges that a more rational and firm funding base be considered during discussion of redistribution of the IHS base and that Memorandum 81-5 be firmly rejected in principle and fact.

6. The Pascua Yaqui Tribe supports the recommendations of the Intertribal Council of Arizona regarding the 25% blood quantum and limiting use of IHS facilities by non-Indians.

7. There have been unconfirmed reports of plans to close the Tucson Area Office (ORD). The Yaqui Tribe receives substantial tribal support services from this Area Office. Services include:

   (1) administrative and contract services
   (2) maintenance and repair of health facilities
   (3) medical consultation
   (4) sanitation services
   (5) environmental health consultation
   (6) program planning and management support
   (7) budget and accounting assistance
   (8) data collection and analysis

   The Tribe recommends that area functions be continued in Tucson even if the Research and Development and training functions are terminated. If the entire office is closed the Tribe requests the 20% of the Area Office budget, or that part of budgeted activities allocated to Yaqui matters and services,be transfered to the Tribe.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE
ROCKVILLE, MARYLAND

INDIAN SELF-DETERMINATION MEMORANDUM NO. 81-5

FUNDING LEVELS AND ADJUSTMENTS FOR P.L. 93-638 CONTRACTS NEGOTIATED ON THE BASIS OF BUDGET PROPOSALS

Sec.
1. Purpose
2. Background
3. Policy

1. PURPOSE: To provide a sound basis for negotiation of P.L. 93-638 (The Indian Self-Determination and Education Assistance Act) contracts at a provisional funding level since negotiation takes place before the beginning date of contract performance and usually before the appropriation is enacted. Also, to provide a procedure which will ensure full disclosure between the contractor and the Federal Government at the time of negotiation of the factors affecting the potential funding level of the contract, and which will specify that the government's obligation is limited to that authorized by the final approved funding level of the contract.

2. BACKGROUND: In order to ensure adequate consideration of contract issues and to permit scheduling of contract negotiations in an orderly fashion and in conformance with the Secretary's initiatives to effect timely procurement planning, it is necessary and desireable to negotiate contracts far in advance of the beginning date of performance and of the enactment of the act appropriating funds necessary for support of the contract during the fiscal year in which the performance is to take place.

After the tribe communicates to the Area/Program Contract Proposal Liaison Officer (CPLO) its interest in a new or continuation 638 contract, the CPLO and other Area/Program Office staff working with the proposed contractor will determine a REALISTIC PROGRAM LEVEL for use by the proposed contractor in the development and submission of the contract proposal. This realistic program level may take into consideration a variety of factors including prior year program level, the President's budget request, and mandatory cost increases, and will serve as the basis

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Date: August 14, 1981

for negotiation of the contract. It must be understood, however, that in the absence of an appropriation act, a PROVISIONAL FUNDING LEVEL, established by the Area/Program Director, will be reflected in the contract to provide a clear understanding of the funds available for expenditure at the beginning of the contract period.

A provisional funding level for a contract to be performed in the next fiscal year will be negotiated on the basis of the most current funding information available at the time of negotiations. Depending on the time of year negotiations take place, the most current funding information is the:

A. Previous year's level of funding for the contract, or
B. Lower figure of the President's budget request for the next fiscal year or the House or Senate or Conference committee actions on the President's budget request, or
C. Funds made available by one or more continuing resolutions enacted by the Congress authorizing the IHS to spend funds at a specified level until an appropriation is enacted.

This provisional funding level is subject to adjustment when the appropriation is enacted and the FINAL FUNDING LEVEL for IHS direct and tribal 638 contract programs is determined.

It must be recognized that such provisionally funded contracts present a risk to the contractor since there is no assurance that appropriations by the Congress will be at the provisional levels, or for the purposes, initially reflected in the contracts. In addition, fiscal restrictions may be imposed upon the IHS by Congress, the courts, or other levels of government beyond the control of the IHS which may require adjustments in the amount of funds available. Accordingly, if the contractor spends at the provisional funding level, there is a risk that the amount of funds that become available after the appropriation is enacted may not be sufficient to support the contract at the provisionally funded level. On the other hand, if the contractor operates at the lower of either the level of the prior year's funding or the level authorized for IHS activities by a continuing resolution of the Congress until the appropriation is enacted, the risk is diminished.

After enactment of the appropriation, the final funding level for the contract is determined by the Area/Program Director. If the final funding level is greater than that which was provisionally funded, the level of effort may be expanded and additional funds added by appropriate modification of the contract. However, if the final appropriation does not result in an increase in the level of funding of the program(s) contracted for, or results in a decrease in such level, the provisional levels of effort and funding will become final or will have to be adjusted downward in accordance with the "Availability of Funds" provisions of such contracts.

The negotiation of a provisional funding level represents a judgment that, if the provisional level for the program(s) involved is funded in full, this level becomes the amount the "... Secretary would have otherwise provided for his direct operation of the programs or portions thereof for the period covered by the contract." (Sec. 106(h), P. L. 93-638). If the provisional amount for the programs involved is not funded in full through the appropriation process, however, the Secretary retains the right to revise his judgment in light of the changed conditions in order to assure that the appropriate priorities in funding are maintained.

In making such a revised judgment, consideration will be given to the previous year's level of funding of the contract involved, as well as other program activities affected. However, while the level of funding in a previous year for a program activity, whether operated directly by the IHS or under a tribal 638 contract, may give rise to an expectation of support at least at the same level for the next year, it does not create an entitlement to, or mandatory base for, that level of support even if the IHS has used such base funding levels to project funding requirements. For example, as noted in the reports of the House and Senate Committees on the Appropriation Bill, 1982 -- House Report No. 97-163 on page 78 and Senate Report No. 97-166 on page 76, the Congress is concerned about the equitable distribution of program funding for health services. The Senate committee directed "... that $2,000,000 be derived from a reallocation of existing Indian Health Service resources" in FY 1982 for such purpose. If enacted, this directive will require adjustment of the base level of funding of both IHS direct and tribal 638 contract programs to permit the more equitable distribution and reallocation of IHS resources.

Funds Distribution

The funds appropriated by the Congress are allocated to the 12 IHS Area/Program Offices by IHS Headquarters. This allocation is based on a number of factors including the funding level of programs (both IHS and tribal delivery) in the preceeding fiscal year, the budget, and changes which must be made such as initiatives mandated by the Congress and restrictions or directives imposed on the IHS by the Congress, the courts, or other levels of government beyond the control of the IHS.

The Area/Program Director determines sub-allocations to support IHS direct and tribal 638 contract programs using the same proportionate increase or decrease in funding levels imposed on the IHS and allocated to the Area/Program Offices. Thus, equity must be maintained throughout this appropriation, allocation, and sub-allocation process.

As an example of a restriction or directive imposed on the IHS, the Congress directs the IHS to conduct a new program or to continue an ongoing program and specifically, or by implication, directs the IHS to support all or part of such program from "available funds". The IHS Headquarters determines the amount and source of funds necessary to support the activity. The "Advice of Allowance" issued to the respective

Area/Program Director reflects the funding level for the activity affected in the Area/Program Office. Each Area/Program Director identifies the sources of funds used to support the directed activity, applies such funding levels to IHS direct and tribal 638 contract programs affected using the same proportionate decreases in funding level as that imposed on the IHS, and revises tribal 638 contract provisional funding levels accordingly.

3. POLICY:

A. The budget activities and corresponding sub-activities and sub-sub-activities comprising the programs funded under the Indian Health Services budget are:

- Clinical services:
  - IHS and tribal health delivery:
    - Hospital and health clinic program
    - Dental health program
    - Mental health program
    - Alcoholism program
    - Maintenance and repair
  - Contract care
- Preventive health:
  - Sanitation
  - Public health nursing
  - Health education
  - Community health representative program
- Urban health projects
- Indian health manpower
- Tribal management
- Program management

B. In the absence of an appropriation available for obligation to support activities for the period covered by a tribal 638 contract proposal, a 638 contract (whether a new or renewal contract) will be negotiated at a provisional funding level incorporating the enclosed "Article ______. Level of Effort and Contract Funding". This provisional funding level will be based on the most current funding information available such as the prior year funding level, or the lower figure of the President's budget request or the House or Senate Appropriation Committee actions, or on one or more continuing resolutions enacted by the Congress. Such provisional funding level will be fixed by the Area/Program Director during negotiations based on instructions from IHS Headquarters to the Area/Program Offices regarding the authorized obligational levels for the various activities conducted by the Areas/Programs pending the enactment of the appropriation.

If both the contractor and the IHS understand the implications and risks involved in negotiating a provisional funding level on the basis of a pending appropriation request, and if actual expenditures under the contract are made at a lower level -- either the previous year level or on the basis of funds made available by one or more continuing resolutions enacted by the Congress --, the risk of deficit spending under the contract is reduced.

C. When the appropriation is enacted and apportioned to the IHS, Headquarters will issue an "Advice of Allowance" to each Area/Program Office based on the total funds available to the IHS.

When the Congress adopts, in the appropriation act, an increase or decrease in the President's budget request for an IHS budget activity, IHS Headquarters will reflect the same proportionate increase or decrease in funding for that activity in the "Advice of Allowance" to each Area/Program Director. Each Area/Program Director will apply the same proportionate increase or decrease to IHS direct and tribal 638 contract programs. The Area/Program contracting officer will notify the contractor in writing of the final funding level for the contract and modify the contract accordingly.

D. Similarly, in the case of any other restriction or directive beyond the control of the IHS which requires the IHS to absorb the cost of an activity from available funds, IHS Headquarters will determine the amount and source of funds necessary to support the activity and issue an "Advice of Allowance" to each Area/Program Director which will reflect the funding level for the affected activity in each Area/Program Office.

Each Area/Program Director will apply the same proportionate increase or decrease to the IHS direct and tribal 638 contract programs affected and will direct the Area/Program contracting officer to revise and finalize tribal 638 contract provisional funding levels accordingly.

E. It may occur that the Congress or some other source beyond the control of the IHS will make it necessary to adjust IHS program operating funds, i.e., base level of funding, in order to achieve an equitable reallocation of existing IHS resources. The same proportionate increases or decreases in base funding levels will be made to both IHS direct and tribal 638 contract programs. All tribal contractors affected by an adjustment decreasing the base funding level will be promptly advised by the Area/Program Director of the need for such adjustment and will be given an opportunity to discuss the proposed reduction before the reduction is made.

F. The determination of the provisional and final funding level for each activity, sub-activity, and sub-sub-activity for each tribal 638 contract by the Area/Program Director must comply with the requirements of Section 106 (h) of the Indian Self-Determination Act (P.L. 93-638) and 42 CFR 36.235 of the implementing regulations, that 638 contracts shall be funded at a level not less than the Secretary would have otherwise provided for the direct conduct of the activity for the period covered by the contract involved. It is also the responsibility of the Area/Program Director to comply with the Anti-Deficiency Act in determining funding levels.

Emery A. Johnson, M.D.
Assistant Surgeon General
Director, Indian Health Service

Article ___________. Level of Effort and Contract Funding

a. In accordance with Indian Self-Determination Memorandum No. 81-5, the contractor's proposal dated ______________, which is incorporated herein by reference and described in general terms, in the Scope of Work (Article ________ of the contract), reflects a realistic program level estimated at $__________. This program level has been structured and negotiated in the context of realistic expectations to serve Indian people.

b. However, it is recognized that the actual amount of funds that will be appropriated and allocated for this contract is unknown at this time and it is uncertain as to whether or not it will be sufficient to fund the realistic program level identified in a. above. Accordingly, and in order to permit an orderly processing of requirements while simultaneously avoiding Anti-Deficiency Act implications, the provisional funding level for this contract for the period ___________, 19__ to ___________, 19__ is set at $___________. This provisional funding level, based on the most current funding information available at the time of negotiations, authorizes commencement of performance prior to the actual enactment of an appropriation. It is further understood that this provisional amount is subject to the "Availability of Funds" provision (Article _____) and the "Limitation of Cost" clause (General Provisions Clause 3) of this contract. *(See Note 1)

c. When the appropriation is enacted and definitive funding is allocated and identified to the contract effort in accordance with the "Availability of Funds" provision (Article ____), the contracting officer will notify the contractor of the final funding level. The contract will be amended to reflect the final level of effort and funding.

d. Any additional funds which may become available as a result of the final appropriation and allocation will be utilized to fund increased levels of effort up to the realistic program level identified in a. above. Such increases in funds and corresponding levels of effort will be added by appropriate modification to the contract. **(See Note 2)

*NOTE 1: A provisional funding level for a contract to be performed in the next fiscal year will be negotiated on the basis of the most current funding information available at the time of negotiations. Depending on the time of year negotiations take place, the most current funding information is the:

A. Previous year's level of funding for the contract, or
B. Lower figure of the President's budget request for the next fiscal year or the House or Senate or Conference committee actions on the President's budget request, or
C. Funds made available by one or more continuing resolutions enacted by the Congress authorizing the IHS to spend funds at a specified level until an appropriation is enacted.

This provisional funding level is subject to adjustment when the appropriation is enacted and the final funding level for IHS direct and tribal 638 contract programs is determined.

Article __________. Level of Effort and Contract Funding (continued)

**NOTE 2: When funds are made available in sufficient amounts to attain the realistic program level identified in a. above, the modification increasing the amount of the contract can simply indicate the Government's intent to fund and obtain performance at that level. However, when an amount is made available which is less than that required for the realistic program level, but more than the provisional funding level listed in b. above, the contractor, in keeping with the philosophy of Indian Self-Determination, should be provided the opportunity to identify those additional features of his proposal which he wishes to pursue. Elements of the realistic program level not included in the provisional funding level should be identified and costed out during negotiations. Such costs should then be made a matter of record in an attachment to the Negotiation Summary and should be signed by the contractor. This document can then be utilized as the basis for modification of the contract, as jointly agreed to, without reopening formal negotiations.

RENO-SPARKS
INDIAN COLONY
TRIBAL COUNCIL
98 COLONY ROAD
RENO, NEVADA
89502
(702) 329-2936

RECEIVED FEB 19 1982

February 16, 1982

To Whom It May Concern:

Please enter the attached TESTIMONY ON FY 82' IHS BUDGET in your official record of testimonies.

Sincerely,

Lawrence Astor

Lawrence Astor, Chairman
Reno-Spark Tribal Council

LA:jd

Attachment

TESTIMONY ON FY '82 IHS BUDGET

Testimony on the impact of fiscal year 1982 budget reductions on Indian Health Service funded and operated programs for the Senate Select Committee on Indian Affairs, Phoenix, Arizona, February 15, 1982.

PRESENTED BY:

RENO-SPARKS TRIBAL COUNCIL 98 Colony Road Reno, NV 89502	NEVADA URBAN INDIANS, INC. 917 East Sixth Street Reno, NV 89512

The Reno-Sparks Indian Colony, a 28.38 acre tract of land situated between the cities of Reno and Sparks, home to 626 persons; and the Nevada Urban Indians, Inc., a non-profit Indian organization that provides health and social services to 2,100 urban Indian people of the Reno-Sparks metropolitan area, present this testimony on the impact of the 1982 Indian Health Service budget cuts. This unique alliance of a tribal and urban group was born out of necessity as a realistic approach in planning and meeting the health needs of all the Indian people residing in the Reno-Sparks metropolitan area.

The Health Center was born for the following reasons:

1. The Indian Health Service health delivery system was unresponsive to the Reno area health needs because of a 200 mile distance, the regulation of the system, and the minimal care available.
2. The Reno-Sparks Indian Colony chose to assume responsibility for the welfare of its people, thus implementing the intent and meeting the spirit of challenge in the Indian Self-Determination Act (P.L. 63-638) and the Indian Health Care Improvement Act (P.L. 94-437).
3. To meet tribal goals of providing acceptable, accessible, and available health care in a cost effective and efficient manner.

In 1979, dollars spent for transportation to the IHS Schurz Service Unit from the Reno area was estimated to be $250,000 without any direct care provided. The current budget to provide direct care at the Health Center is $222,000. Services have been improved 600% for less money. But money expended that is recirculated in the community and employs Indian people in professional capacities.

Past testimony and the attached chronology displays the leadership the Reno-Sparks Indian Colony has taken to promote and assure acceptable, assessible, and available health care for Indian people in a cost effective and efficient manner. As you will note through the chronology, it has been a difficult and frustrating task taking years of planning and study, continued effort in turning planning into reality, and the never ending white-tape that places stumbling blocks in the way of achieving Indian "self-determination". The budget cuts for 1982 and those anticipated for 1983, mean many of the gains made will be lost and health care costs will escalate even further.

Reno, as well as the whole of Nevada, is being dramatically impacted by the Indian Health Service cuts in the Community Health Representative Program (20.7%) and the Tribal Management Program (13.0%). It is from these two categories that the Reno-Sparks Tribal Health Center's primary care services are funded because of reluctance on the part of the Phoenix Area Office to contract out of clinical services. The effects of the proposed cuts will hurt the quality and availability of services because Health Center operating time, staff hours, and supplies, including medication, cutback will be a minimum of 20%. This translates into a minimum reduction of 600 patient visits, 100% transportation services, and possibly 100% mental health services and alcohol prevention. Also, effecting the quality and availability of services is rising inflation and rising unemployment. Persons formerly holding group insurance will soon loose it; third party mechanisms will not be a viable resource.

Contract care, although not experiencing a cut in 1982, is of concern to us as historically; contract care funding has never been adequate to meet the need. The Schurz Service Unit contract care budget is generally expired by the 7th month of operation and again, inflation is stretching already insufficient funds and creating a delivery of crisis care that causes costs to increase rather than provide preventative care which produces long term savings.

The 8.3% cut to Urban Indian Health Projects has caused minimal problems of the Nevada Urban Indians, Inc. Health Program; but, a proposed zero budget for 1983 is of obviously major concern. Benefits from the cooperative agreement between the Reno-Sparks Indian Colony and Nevada Urban Indians regarding health planning and the Reno-Sparks Tribal Health Center is in jeopardy if urban Indian health is cut drastically or eliminated. The track record of a tribal and urban entity initiating a cooperative relationship is demonstrated proof that combining administrative entities improves the quality and quantity of health care. Since this model was put in place, outpatient services in the area have increased 600%, but patient visits are only at 3.3 per annum. Accessibility, therefore has dramatically increased the "bang" for the dollar. This has not been an easy task, however, as rules/regulations and government offices/personnel are not attuned to this idea.

Finally, we wish to address the formulas that have been developed to prioritize construction and equity health care funds. We feel the formulas do not allow a prioritizing that reflects the true need, especially for the rural and isolated areas in Nevada. This concern is of mutual interest to all Nevada tribes and Indian groups.

We end this testimony by providing the following request that Congress honor its own legislative mandates and strengthen its commitment to serve the first Americans of this country.

1. An appropriation of clinical center funds be made to fund the Reno-Sparks Tribal Health Center as community health centers have proven to be cost effective and efficient.

2. Funds for CHR type programs continue to be made available; however, each Tribe should be allowed flexibility to follow their Tribal Specific Health Plan.

3. Contract care in Nevada be funded at twice the level to meet the stated need, as documented in recent studies.

4. Continue to fund urban Indian health at its present level to assure the continued cooperative effort of tribal and urban initiatives and support realistic alliances that deliver quality health care.

5. Challenge Congress to meet previous commitments regarding the Tribal/Urban Specific Health Planning Process by allocating time and resources per legislative design.

6. Assure that the intent of P.L. 63-638 (Indian Self Determination) is afforded Indian people through adequate appropriations and federal agency compliance with established regulations.

CHRONOLOGY OF EVENTS

Reno-Sparks Tribal Council's Attempt to Establish a Local Health Center

1960's	As part of the community development process, the Tribal Council identifies health as a major deterrent to high quality life in the Colony. A sewage project and community park project are initiated in 1966. The first of five housing projects is started in 1968.
1970's	Continuation of housing projects water and sewage stubbings placed to each assigment. In conjunction with Inter-Tribal Council of Nevada, a Community Health Representative component is started. In-home Health Services are added in 1975.
1973	Tribal Council desires to have a health clinic or hospital in the Reno area. Indian Health Service counsels an evaluation of the Schurz Service Unit be done first.
1974-1975	Western Nevada Indian Health Board sponsors an evaluation as suggested. Conclusion is that the Service Unit hospital is physically inadequate and that most hospital services are not provided. The study recommends tnat 3 or 4 clinics be strategically placed in Indian populated areas.
1976	Reno-Sparks Tribal Council submits a request for developmental funds for a Reno-Sparks Health Facility.
1977	Reno-Sparks Tribal Council submits proposal again to Phoenix Area Office to do a feasibility study for a health center as recommended by the evaluation study. The Tribal Council is invited to Phoenix for negotiations. At the last moment, after the negotiation conference, the Phoenix staff renigs and says to wait for the implementation of P.L. 94-437 (Indian Health Care Improvement Act).
1978 (June)	Reno-Sparks Tribal Council obtains grant and initiates Tribal Specific Health Planning process.
August	Memorandum of Agreement signed with Nevada Urban Indians to plan/provide services in concert.
October	ACTION proposal for nurses submitted.
November	Completion of data and perceived need assessment. Population and criteria set by Congress for accessibility indicate Reno area can support a full health center. In applying RAC (Resource Allocation Criteria), 28 positions are justified, although all parties concerned believe a good prevention, screening and follow-up program can be run with 12.

Negotiations with University of Nevada Department of Family Medicine are opened. Both parties agree to develop the colony clinic as a University satellite for medical supervision/referral and a future training site for Indian medical personnel.

December-January Tribal Council approves action concepts in Tribal Specific Health Plan with provision that inpatient care should be provided through contract with local hospitals (Washoe Medical Center, St. Mary's, etc.)

1979 Tribal Council adopts land use plan.

Tribal Council adopts preliminary management systems and puts them on file with Phoenix Area Office.

Community Health Representative Contract proposal submitted.

A proposal to develop a tribal health center is submitted under PL 93-638 guidelines.

February "638" proposal rejected as being too operational. It is resubmitted as a demonstration grant. There is no further documentation as to acceptance, rejection, etc.

ACTION proposal approved.

March Notification that CHR contract is under "Final negotiation".

University representative makes appointment to meet with IHS officials regarding cooperative arrangement; travels to Carson City to meet with them only to find meeting has been cancelled with no notification.

Tribal Specific Health Plan adopted.

National recruitment for physician assistant begins.

Staff is invited to Phoenix to negotiate CHR contract, 638 contract. Nothing happens.

April Tribal Council presents Tribal Specific Health Plan to the Nevada Congressional delegation and makes formal request of Congress for FY '80 add-on to continue momentum of project. Indian Health Service ultimately testifies against the Tribe saying it should wait until another feasibility study is done on all the Tribes in the Service Unit.

"638" Grant revised as requested and resubmitted. Again, there is no official response, thus violating 638 guidelines for the second time.

Tribal Council requests technical assistance to study HMO concept upon consultation with IHS Rockville staff.

May	Receipt of notice of successful pre-application to HUD for construction of 3,000 sq. ft. of clinical space. Dr. George Blue Spruce, Area Director, visits Colony; views plans. Further discussions between PAO/IHS STAFF and Tribe over Health Center is not productive. IHS suggests emergency facilities should be included; Tribe does not feel it can justify construction, equipment, or staffing dollars when Washoe Medical Center is only four blocks away. Pyramid Lake Tribe designated to be lead on Master Facilities Plan.
June	Discussions with IHS regarding health center proposal drag on. Request for HMO study is "indefinately shelved" by Emery Johnson. PID (Program Information Document) submitted by PAO/IHS. No response. Phoenix Area staff quote "I don't care what the Tribes want" when challenged on plans.
July	The no action phase drags on.
August	Award notice of $200,000 HUD funding for interim health center. Tribal Council meets with Dr. Blue Spruce regarding lack of action on all fronts. Final negotiations are held for CHR contract. (Funds do not arrive until mid-October; Tribe must finance program. Computer code not assigned until mid-November, precluding prompt reporting by Tribal Council.) First technical review of HMO concept determines that population base is inadequate; exploration of insurance mechanisms is more appropriate. Demonstration of Well-Person Care Model proposal resubmitted. No response.
September	Phoenix staff arrive to present checks to Master Study Plan and two tribal grants. They announce they will do final negotiations for the Reno project, but once in meeting, refuse to negotiate. Tribe is instructed to again rewrite and have it into Phoenix office in three days. This is done; there is no response. Consortium of health providers (University, Tribe, Inter-Tribal Council) begin semi-weekly planning meetings for health center operation.
October	Phoenix staff publicly states funds will be made available by November 15. Tribes flies in 3 candidates for physician assistant interviews; selects one. Process for selection of support personnel also takes place.

	Western Nevada Health Planners meet to discuss feasibility of IPA mechanism of pre-paid health care.
	Request for TRAIS (word processing) equipment submitted.
November	Tribe is chastized for IPA meeting.
	PAO announces that they would prefer to contract the health center rather than go the grant route. It will still need to be rewritten. Changes in PAO staffing precludes this occurring.
	VISTA's arrive to a non-existant project.
	Planning meetings reach impasse with nothing to work on.
	IHS credibility with University (and Indian community) sinks to all time low.
December	IHS staff says nothing can be done to move health center until after the holidays.
	Master Plan Study first draft summary recommends a clinic or hospital for Reno area.
1980 February	Western Nevada Health Delivery System Master Plan Study completed. Tribes plan strategy for plan implementation.
March	Physician Assistant hired. Weekly staff meetings pick up momentum for the development of protocals and service cycle. Inservice training and community education begins.
August	Health Center Demonostration Grant is negotiated and Health Center is scheduled to open October 1, 1980.
June	Western Nevada Health Delivery System Master Plan Study prioritizes Reno-Sparks for a Health Center. Funds are not available for implementation.
September	Health Center interviews are conducted for a Manager, Medical Records/Bookkeeper, Medical Receptionist, and Driver/Maintenance Man. Positions are hired.
October	Health Center holds open house and begins operation. The weekly trips to Schurz IHS Hospital (200 miles) are almost eliminated for ambulatory care.
1981	Continued development of the Health Center and its services.
	The UNR Family Practice ties are strengthened and mutually beneficial.
	Speciality clinics and services become routine: Diabetic Clinic Risk Reduction Activities Mental Health Services Infant/Child Well Clinic Alcohol and Drug Abuse Prevention Activities
1982	IHS budget cuts jeopardize viability of health center operation.

CARL WALN
President

BEN BLACK BEAR, JR.
Vice-President

Rosebud Sioux Tribe
ROSEBUD INDIAN RESERVATION
ROSEBUD, SOUTH DAKOTA 57570

Incorporated Under Act of June 18, 1934, 48 Stat - 984

PHONE: 605-747-2381

LLOYD B. ONE STAR, SR.
Secretary

CHARLES WHITE PIPE, JR.
Treasurer

1982 FEB -8 PM 2:32

February 1, 1982

REC'D FEB 08 1982

Honorable John Melcher
United States Senate
6313 Dirkesen Senate Office Building
Washington, D.C. 20510

RE: Additional Testimony to the
Oversight Hearing held in
Billings, MT. December 21, 1981.

Dear Senator Melcher:

The Rosebud Sioux Tribe, located in south east central South Dakota, would like at this time to respectfully submit to you additional information that was not covered in our written testimony presented at the oversight hearing held in Billings, Montana, on December 21, 1981.

The Rosebud Sioux Tribe has been appropriated $1.3 million in the FY-82 federal budget for the design and development of a new hospital. We are most appreciative that we are to have a much needed new health facility on our Reservation.

Attached are two Tribal documents that the Tribe would like to have attached as part of the testimony that was presented in Billings.

The issue at point is that the Tribe wants to be on record as supporting a hospital of sufficient size and staff to be effective in reversing exceptionally high local mortality and morbidity rates, and to be effective in eliminating denial of care for reasons of lack of local availability and lack of contract care funds for an outside alternative.

A new replacement hospital must include an adequate surgery program and be of a design to permit future expansion, in the event that population and workload increases warrant this consideration.

In 1972 when the Indian Health Service did a Program Information Document, statistical data called for a 66 bed facility, with surgery. In the most recent updated document for the same hospital, the Indian Health Service contends the Tribe needs a 35 bed facility without any surgical program.

At the same time, the Tribal population has been increasing, but the hospital size has shrunk from 48 beds to 29, through partial condemnation. The surgery program once had long waiting lists; now, it has disappeared entirely for the past several years. There was a period exceeding a year, when the hospital had no blood for transfusions. Meanwhile, the death rate of our people has continued to statistically climb, to a level recently of more than twice that of other Americans.

The Rosebud Sioux Tribe comprises a geographical area of some 125 miles long and 60 miles wide. Within this area are also numerous non-Indians who are medically underserved. The Tribe is willing to consider a facility capable of additionally serving the non-Indian population within its jurisdiction, realizing this would necessitate additional bed space.

We understand the Director of the Indian Health Service has the authority to make a decision on what type of facility will be proposed for construction. The Rosebud Sioux Tribe is, at this time, respectfully requesting the committee to question the Director as to why we should not be able to go ahead with the planning and design of a facility with surgery, and bed space sufficient to satisfy the needs described above.

The Rosebud Sioux Tribe expresses its appreciation for allowing us to submit this additional testimony.

Sincerely,

Carl Waln

Carl Waln
President
Rosebud Sioux Tribe

Enclosures

CARL WALN
President

BEN BLACK BEAR, JR.
Vice-President

Rosebud Sioux Tribe
ROSEBUD INDIAN RESERVATION
ROSEBUD, SOUTH DAKOTA 57570

Incorporated Under Act of June 18, 1934, 48 Stat - 984

PHONE: 605-747-2381

LLOYD B. ONE STAR, SR.
Secretary

CHARLES WHITE PIPE, JR.
Treasurer

POSITION PAPER FOR COMPREHENSIVE/CURATIVE AND PREVENTIVE HEALTH CARE FACILITY PLANNING

ROSEBUD SIOUX TRIBE

The Rosebud Sioux Tribe is in dire need of a major comprehensive curative and preventative health care facility. The old facility was constructed in two phases, with the first being built in 1915 and the second wing being added in 1960. The old portion built in 1915 is condemned as far as in-patient care, and irreparable structurally.

Presently, Medicaid funds have been utilized and still are utilized to allow for remodeling, construction and repair, to bring the old facility toward compliance with Medicare/Medicaid standards and regulations so that continued collection of funds is possible. The present facility has numerous deficiencies in current standards for medical facilities, as set forth by Medicare/Medicaid, and the JCAH.

Due to the inability of the current Indian Health Service Hospital to meet federal hospital standards and regulations, many thousands of dollars have been spent on the upkeep and upgrading of the old facility. These are dollars that otherwise might have been spent on providing direct patient care and dollars that might ahve been spent on providing care when it was instead denied.

Ten years ago, an earlier attempt was made to replace Rosebud's outdated facility. In the Indian Health Service Program Information Document dated December 1972, statistical data called for a 66 bed facility, with surgery. Based on this document, the new hospital plan and design was completed in late 1973. Unfortunately, the new facility was never built, and we are beginning the whole process again.

The most recent Program Information Document by the Indian Health Service, based on caseloads from 1978-1980 contends that the Tribe needs only a 35 bed facility without any surgical program. The Rosebud Sioux Tribe objects totally to the use of patient care caseloads for the years 1978-1980 for bed methodology, for the following reasons.

A. The Rosebud Sioux Tribe is fully aware of the inadequate population figures received for the 1980 Census. Presently and in the future, the Rosebud Health Care Facilities provide service to Tribal members in the counties of Todd, Mellette, Tripp, Gregory and Lyman in South Dakota and to Tribal members located in Cherry County in Nebraska.

During the Census taking, the Tribal members in all counties except Todd were not allowed to fill out the Supplemental Indian Census form to be designated as Tribal member or other Indian people. With this being done the census reflection for the Rosebud Sioux Tribe is only that of Todd County, which lowers the figure by approximately 2,500 Indian people. The Tribe is implementing a Tribal Census Department through the use of the Bureau of Indian Affairs P.L. 93-638 funds, to enable the Tribe to get an exact census in all counties of the Reservation being serviced by the Tribe. Therefore, the Rosebud Sioux Tribe is stating that the census used is inadequate and the Tribal members of other counties should be reflected into the population figures since Indian Health Service provides services to all Tribal members in all counties of the Rosebud Sioux Reservation.

B. Since 1978 through the present, the hospital bed capacity has been reduced from 48 to 29 beds, due to the condemnation for patient care of the older portion, which contained the entire pediatric wing. This decline in bed space directly accounts for most of the dramatic decreases in inpatient case loads that were used in the IHS bed methodology projecting future needs.

C. Due to inadequate staffing and services available during this same period, patients have either been hospitalized elsewhere, or had their care refused, reducing the Service Unit caseload. Examples are lack of surgery, going over a year without blood for transfusion available, and intermittant lack of capability for routine obstetrical delivery. Percent occupancy rates were much higher in the early 1970's, even though the hospital had many more beds to fill.

D. Caseloads for outpatient care were low, due in part to constant rapid turnover among the physicians, over 100 in 1980 alone. Such turnover is not conducive to developing confidence in the hospital or maximizing patient visits. In addition, it has not been unusual for the hospital to be placed on an emergency only basis, closing the outpatient facilities due to physician shortages.

E. Due in part to inadequate facilities, physician recruitment and retention is totally lacking, a major factor causing increasingly lower caseload figures in recent years. Dramatic improvement in efforts toward recruitment and retention are needed, and a new facility, complete with adequate services, space, equipment and housing, will be a significant positive influence on recruitment and retention. With a full staff and adequate services, the caseload figures will markedly increase.

F. The bed methodology used by the Indian Health Service thus far in no way recognizes or accounts for care denied in the past. Care has commonly been denied for reasons of not being currently available at Rosebud, and insufficient contract care funds. Denied care can certainly not be viewed as a non-existant need.

G. The Indian Health Service bed methodology for determining future need does not recognize the current low health status of the Rosebud Sioux people resulting from past insufficiencies. The documented high mortality and morbidity rates prevalent at the Rosebud Service Unit are a cause for great concern, and worthy of consideration in assessing current and future health care needs.

H. The estimated figure for non-Indian population in Todd County is 3,500. Consideration may be made to allow these people to receive services on a fee basis, as well as persons from surrounding areas, assuming adequate bed space was allotted to cover the added non-Indian user base.

I. The Rosebud Sioux Tribe additionally urges that consideration be given to building a facility of sufficient size and staffing to allow it to act as a referral center for other nearby Indian Health Service hospitals. The Aberdeen Area of the Indian Health Service has had no such referral center within their system, placing a tremendous burden on their limited contract care dollars and resulting in denial of care.

Since 1972, when the Indian Health Service determined the needed bed space for the new hospital to be 66 beds, there has been partial condemnation of the hospital, increasing problems with physician staffing, decreased available services, increased denial of care, and statistically verified increases in mortality and morbidity of the Rosebud Sioux people.

The most recent bed methodology based only on what was provided in caseloads from 1978-1980, determined the needed beds to be 35, and determined that no surgical program was needed for the new hospital. The Rosebud Sioux Tribe maintains that these findings serve only to verify how seriously the medical services at the Rosebud Service Unit have declined, and in no way reflects the present or future needs.

Therefore, we strongly urge that during review, the points and issues we have stated be given very serious consideration. If we do not receive adequate bed space and staffing, the new facility will be immediately obsolete, with little hope of improving the health status of our people.

Carl Waln

Carl Waln
President
Rosebud Sioux Tribe

Feb. 1, 1982
Date

RESOLUTION NO. 81-116

OF THE ROSEBUD SIOUX TRIBE

WHEREAS, the Rosebud Sioux Tribe has a critical need for a new health facility to provide essential health services to the Indian people of the Rosebud Sioux Tribe, and

WHEREAS, the Rosebud Sioux Tribe is concerned with the health of all persons residing on its Reservation and would consider a facility available to Indians and non-Indians alike, and

WHEREAS, Rosebud IHS in the past has successfully operated a surgery program which benefited the members of the Tribe as well as the non-Indian patients that were served on emergency basis, and

WHEREAS, present distances to adequate surgical services at Rapid City is 4 hours away or to Minneapolis, MN. which is 8 hours away, and

WHEREAS, the Rosebud IHS hospital receives cases involving critical trauma, patients who need immediate emergency care and/or stabilization for referral for specialized care, and

Whereas, the Obstetrical program presently refers out 50% of obstetrical cases (high risk) due to lack of surgical back-up and obstetrical specialty care, and

WHEREAS, the Surgery program will save $200,000-$300,000 in Contract Health funds and additional needed but currently denied surgery could be performed, and

WHEREAS, referrals to health vendors away from the Reservation creates hardships on the family members of the patients who wish to be with their loved ones during critical illness, and

WHEREAS, the Rosebud Sioux Tribe understands that data for FY-78,79, and 80 is not accurate because of a shortage of physicians and it being necessary to close the pediatrics section for safety reasons, and

WHEREAS, the previous methodology emphasizes only what has been provided in the past rather than what was really needed in the past, and

WHEREAS, the methodology as previously presented by the IHS does not take into account past denial of care for many persons needing hospitalization and surgery due to insufficient local facilities and insufficient contract care funds, and

WHEREAS, the Rosebud Sioux Tribe disagrees with statistical data used in the application of the bed methodology which determines bed size of a replacement hospital and thereby reducing the bed capacity from 45 to 35, NOW THEREFORE BE IT RESOLVED, for these above reasons the Rosebud Sioux Tribe now directs the IHS to utilize data for FY-72 to 77 which gives a more accurate workload statistical base in the recalculation of hospital beds and the IHS seek out what ever authority is necessary to waiver the requirements for the three years of bed methodology application, and be it

FURTHER RESOLVED, that additional methodology be developed to take into account the exceedingly high mortality and morbidity rates on the Rosebud Reservation, and the level of services that would be required to impact on these exceptionally high rates so that the health status of the Rosebud Sioux people can be brought to the level enjoyed by other Americans, and be it

FURTHER RESOLVED, that such methodology for determining the replacement hospital size will emphasize need rather than the inadequate level of services provided in the past and will take into account denied contract care services and denied surgical care as a further reflection of such need, and be it

FURTHER RESOLVED, the Rosebud Sioux Tribe is firm in its committment for new replacement hospital including an adequate surgery program and that such facility will be of a design to permit future expansion of additional health program as population and workload increase, and be it

FURTHER RESOLVED, that the Rosebud Sioux Tribe will not relent in its efforts to insure that a replacement facility be constructed to serve the Rosebud Sioux Reservation, and be it

FURTHER RESOLVED, that the Chairman and Officers of the Rosebud Sioux Tribe be charged with the full responsibility of representing its members in efforts to acquire said facility.

CERTIFICATION

This is to certify that the above Resolution No. 81-116 was duly passed by the Rosebud Sioux Tribal Council on December4, 1981 by a vote of twenty-seven (27) in favor, none (0) opposed, none (0) not voting. The said Resolution was adopted pursuant to authority vested in the Council a quorum was present.

Carl Waln

Carl Waln, President
Rosebud Sioux Tribe

ATTEST:

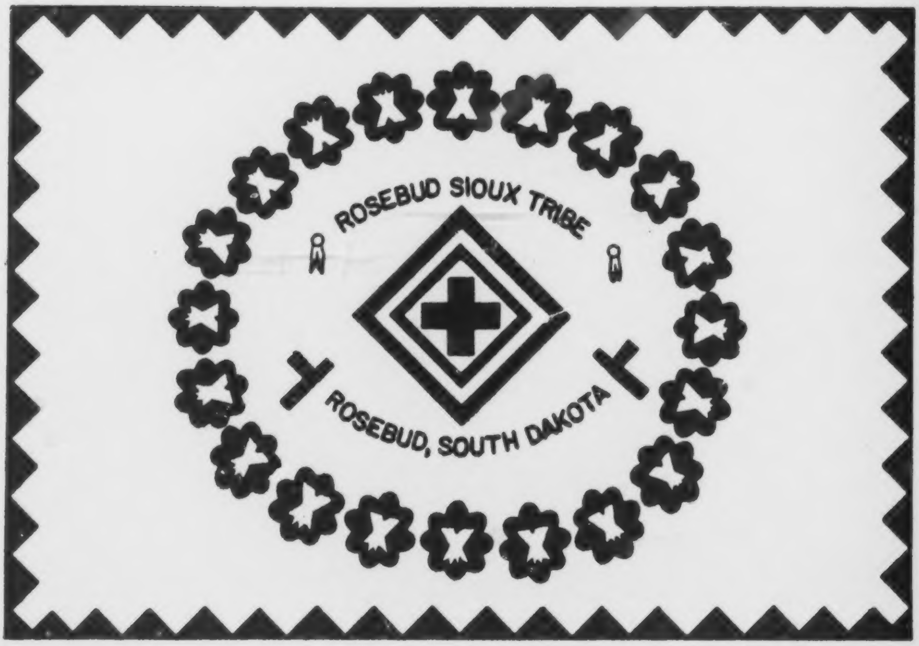
Lloyd B. One Star Sr.

Lloyd B. One Star, Sr., Secretary
Rosebud Sioux Tribe

EVALUATION REPORT OF DEFICIENCIES

INDIAN HEALTH SERVICE HOSPITAL

ROSEBUD, SOUTH DAKOTA


ROSEBUD SIOUX TRIBE
ROSEBUD, SOUTH DAKOTA

INTRODUCTION

The purpose of this report is to summarize as succinctly as possible the findings of an on-site facility analysis of the existing USPHS Indian Hospital at Rosebud, South Dakota.

This report presents as objectively as possible the present functional and physical condition of the hospital facility as observed in September 1981.

The standards by which the facility was judged include the following:

Minimum Requirements of Construction and Equipment for Hospital and Medical Facililties. DHEW Publication No. (HRA) 79-14500.

NFPA 101 Life Safety Co 1979 Edition. National Fire Protection Association.

Uniform Building Code Standards 1979 Edition.

Standards of the Joint Commission on Hospital Accreditation. Accreditation Manual. 1981 Edition.

EXHIBIT 1 - PROGRAM/SPACE DEFICIENCIES

The present hospital program suffers from cramped, poorly located, and poorly arranged spaces. The overall physical arrangement is totally outmoded for safe and efficient health care delivery.

Several departments are not capable of being remodeled or expanded to make them acceptable for their present functions, nor for future anticipated workloads of the 1980's and 1990's as described in the Program Information Document.

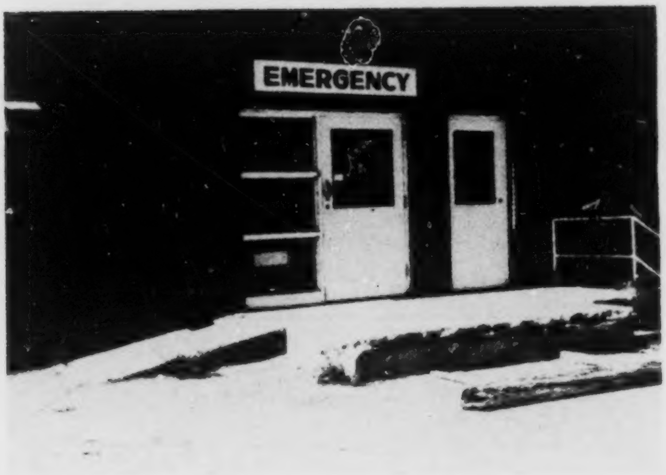
Itemized deficiencies in the various departments are as follows:

EMERGENCY SUITE

No protected ambulance entrance.
No grade level entrance with automatic doors.
No 24-hour nurses station for direct observation.
No stretcher and wheel chair storage area.
No public waiting space with toilet facilities.
No charting/work area for staff.
No space for multiple accident victim care.

RADIOLOGY SUITE

No separate gowning and waiting area with access to toilets.
No holding area for stretcher patients.
No film viewing area for physicians and technicians.
No administration area.
No X-ray film storage (records) area.
No handwashing facility in radiographic room.
X-ray room too remote from emergency area.



EMERGENCY RECEIVING ENTRANCE

Unprotected ambulance entry lacking grade level access with automatic doors.

LABORATORY

No centralized lab space for efficient supervision.

No central lab storage area adjacent to work areas.

Poor ventilation and exhaust of fumes, etc.

No separate speciman collect area for blood draw, etc.

No reception, administration, reception areas.

PHARMACY

No space for laminar flow hood.

No space for unit dose drug packaging.

No space for IV solution preparation - storage.

No office areas for pharmacist or clerk.

CENTRAL STERILE SUPPLY

No separation of soiled receiving from clean work area.

No separate decontamination workroom with sinks, etc.

No employee lockers, showers, or toilets close by.

No clean equipment storage room.

No cart storage or sanitizing facilities.

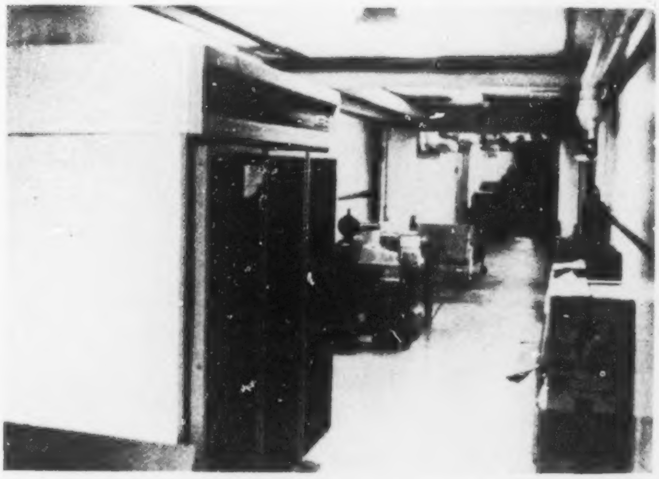
DIETARY DEPARTMENT

No bulk dry food storage.

No walk-in freezer or refrigerator storage.

No employees lockers, toilets, or handwashing in area.

Receiving dock too remote from kitchen.



Laboratory equipment stands in corridor for lack of space.

Laboratory work areas not adequate for equipment nor storage.

LABORATORY AREAS

NURSING UNIT

No report-conference room for nursing staff.

No separation between clean and soiled utility rooms.

No nurses locker room (taken for supplies storage).

No nourishment station.

No wheelchair or stretcher parking area.

No isolation room with ante room entry.

No disturbed patient room.

No public toilets on unit for visitors.

INTENSIVE CARE UNIT

No nurses station located for direct observation.

Not enough space for 7'-0" clear between beds.

No single bed coronary care rooms.

No soiled utility with direct access for bedpan disposal.

No nourishment station.

No emergency equipment-storage area.

No storage for patients personal effects.

No family waiting room.

No public toilets for visitors.

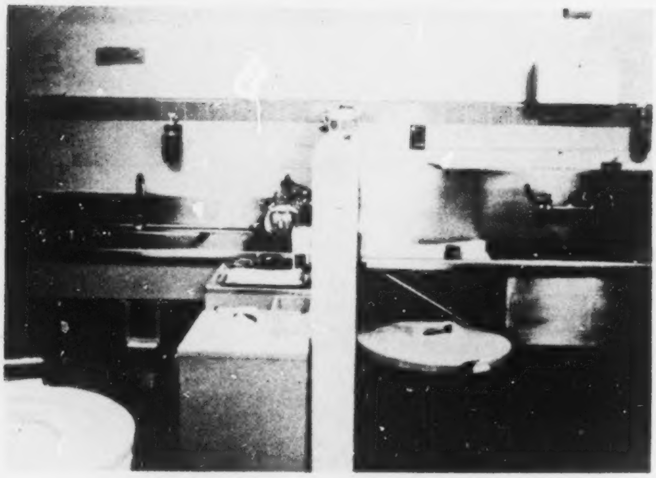
SURGERY SUITE

No control/reception station for unit nurse.

No stretcher park area inside the suite.

No staff gowning/lockers area with direct access.

No isolation from public traffic areas.

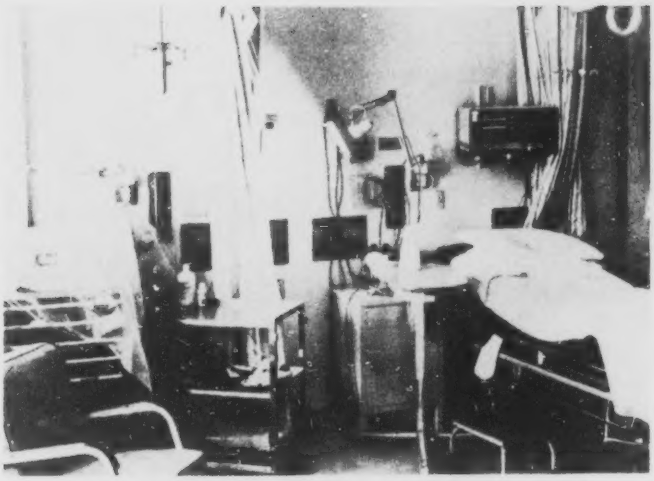


NURSING UNIT UTILITY ROOMS

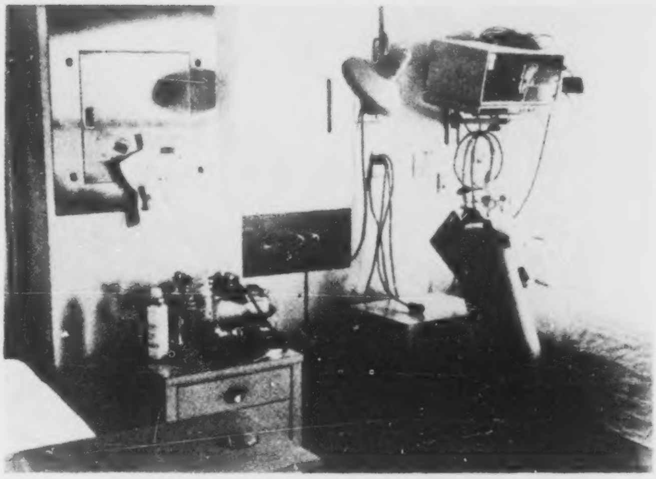
No separation between clean and soiled work areas invites possibility of cross infection.

CLEAN UTILITY WORK AREA

INTENSIVE CARE UNIT



Equipment and outlets poorly arranged for proper access.



Piped medical gases not available at beds. Portable gas equipment blocks access to patient.

No adequate recovery room.

Operating room is below minimum size.

No anesthesia storage room.

No anesthesia work room.

No sterile and clean supply room.

OBSTETRICAL SUITE

No nurses station for control and observation.

No staff gowning/locker area with direct access.

No emergency delivery - labor room.

Only one labor room existing. Minimum need is two.

No drug distribution station within suite.

No clean supply room.

No anesthesia workroom.

No stretcher parking alcove within suite.

CENTRAL STORES

No central organized storage area or storage system.

No central dispensing of supplies.

No office areas for dispensing clerks.

No separate supplies receiving area/check in.

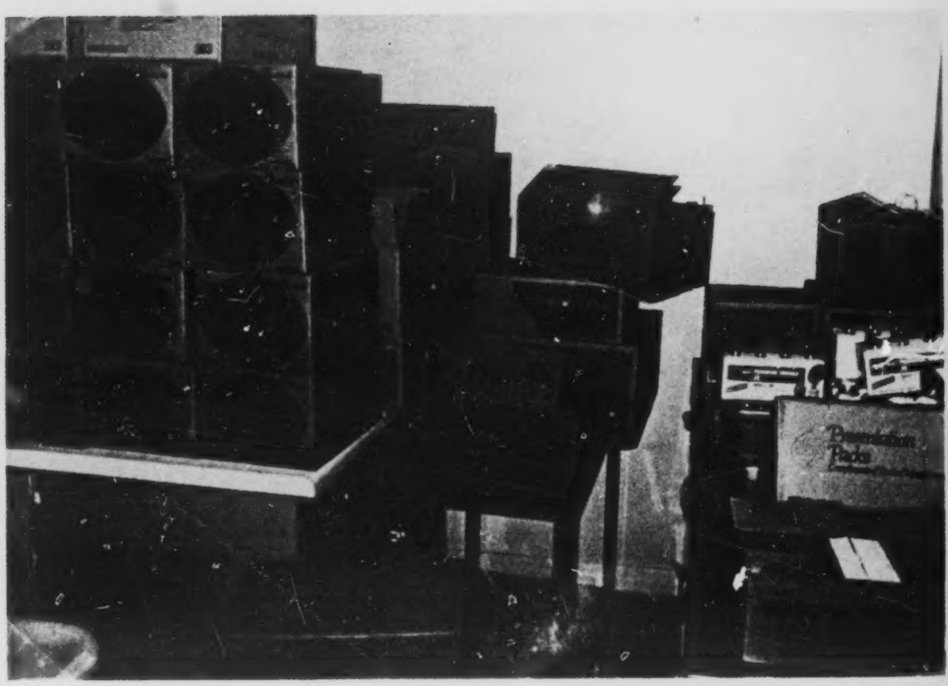
PEDIATRICS NURSING SUITE

No multipurpose/play space near patient rooms.

No storage area for play equipment (in corridor).

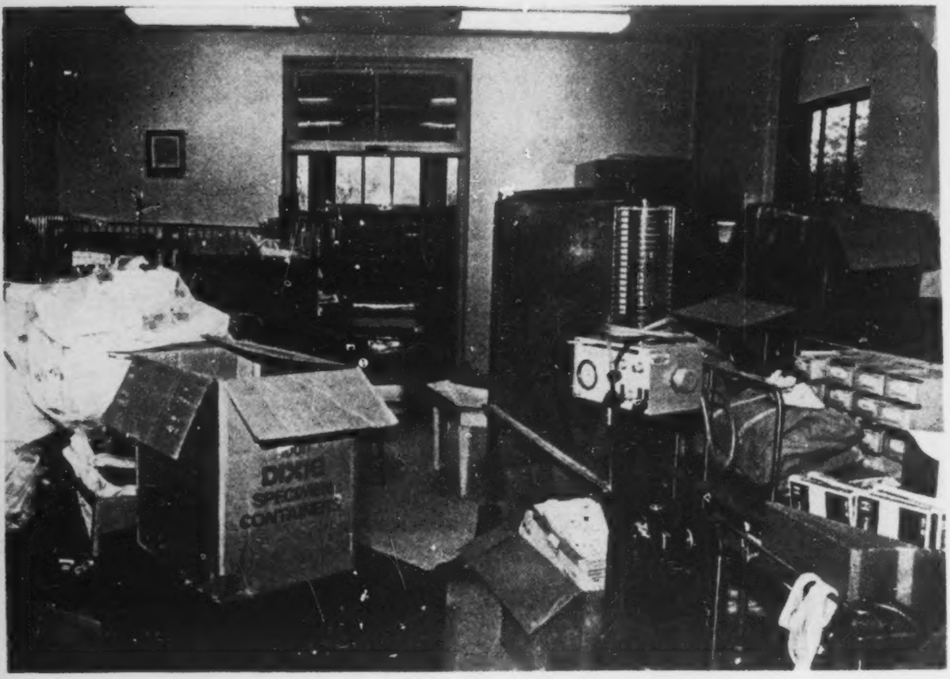
No toilet accessible to play space.

No separate nourishment station for formula prep., etc.



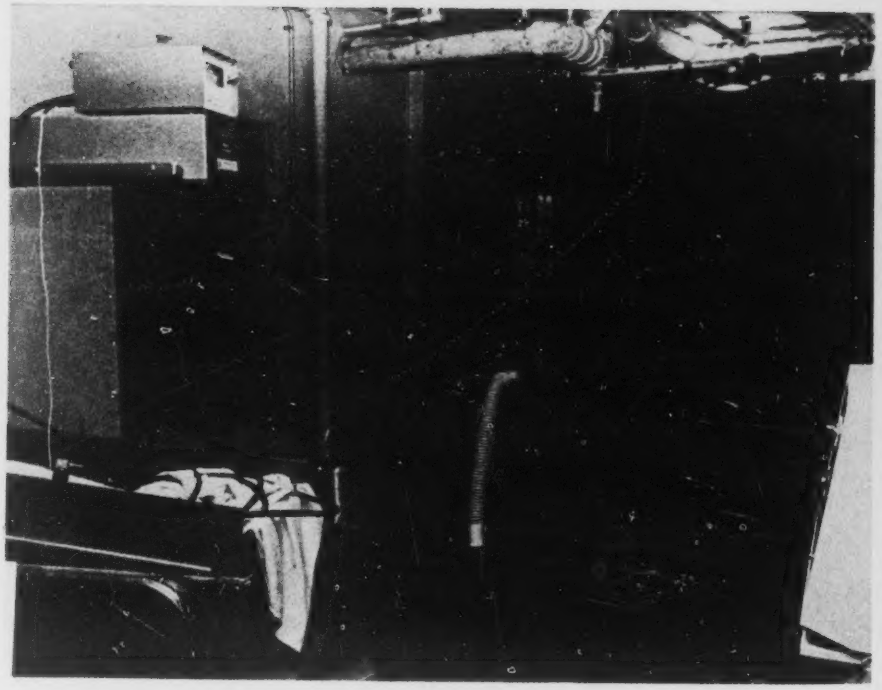
MEDICAL SUPPLIES STORAGE

Note disorganized storage facilities in several decentralized storerooms throughout hospital.


Dixie
SPECIMEN
CONTAINERS

EQUIPMENT STORAGE ROOM

Lack of proper central storerooms causes disorganized storing of equipment.



MEDICAL EQUIPMENT STORAGE

Note the lack of clean storage space for medical equipment.

LINEN SERVICES

No central soiled linen receiving, holding and sorting room.

No clean linen receiving, inspection, mending, holding and dispensing areas.

No linen cart storage areas.

OUTPATIENT SERVICES

No central clinic facilities separate from inpatient facilities.

Clinic areas are dispersed in several areas of the hospital buildings and out buildings.

No central reception and records area.

No physicians office space for consultations.

No administrative areas for outpatients.

MORGUE AND AUTOPSY

No staff locker and change area with shower and toilet. Remote location from service entry.

In summary, it is obvious that the existing facilities lack much of the basic functional space necessary to deliver todays health care services.

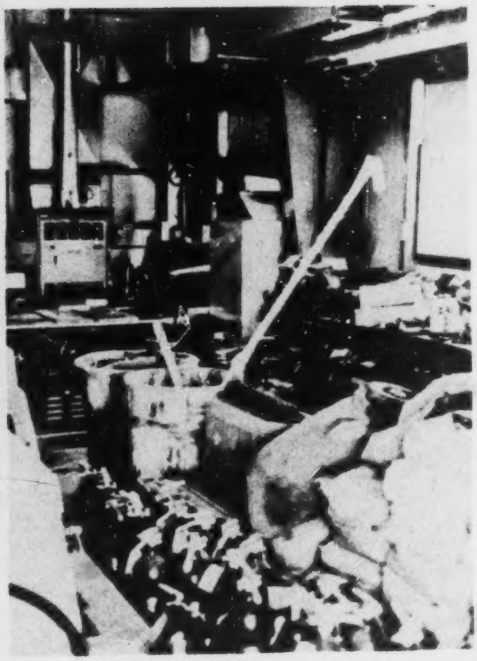
There is no ability for this facility to be expanded to meet any increased future level of services, much less to bring the facility up to standard to meet present day needs. The facility is functionally outdated; is marginally getting by.

CENTRAL STORES BUILDING

No direct connection for access to supplies.

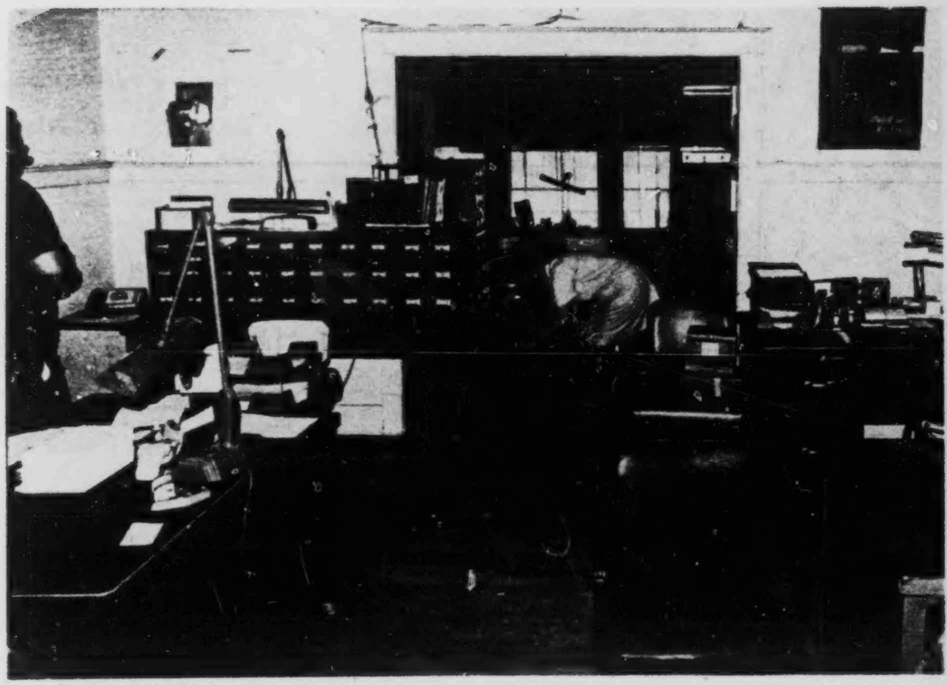
EYE CLINIC BUILDING

Decentralized and dispersed outpatient services reduce efficiency and access to patient records.



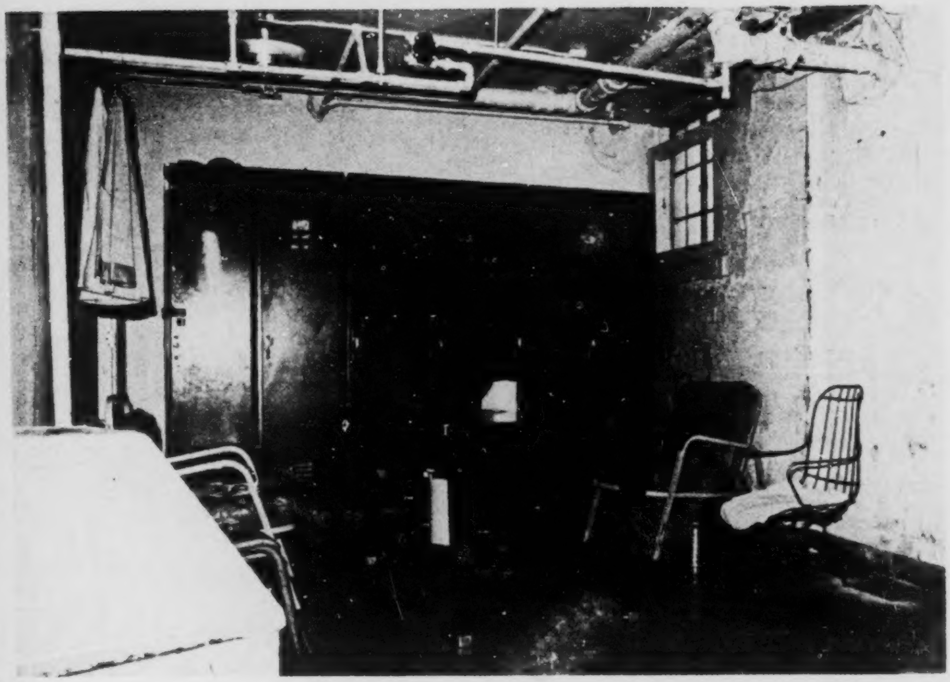
CENTRAL STORES BUILDING

Space is cramped for bulk purchasing. No central dispensing area is available.



FIELD HEALTH OFFICES

Poorly equipped work spaces and crowded working conditions reduce performance and efficiency.



EMPLOYEE LOCKERS

Note building deterioration from moisture penetration.

EXHIBIT #2 - PHYSICAL DEFICIENCIES

Evaluation of Building "A" (Hospital Addition, 1960)

Building Code Deficiencies

Shaft enclosures are not of 2-hour construction.

Excessive dead-end length on second floor at Obstetrics Department (+50 feet).

No smoke doors on 2nd floor.

Glass vision panels in doors at corridors must be wired glass, not clear.

Doors in corridors are not allowed to have vent louvers in them.

Exit door width must be 42" minimum.

Corridor walls with glass vision panels must have wired glass not clear glass.

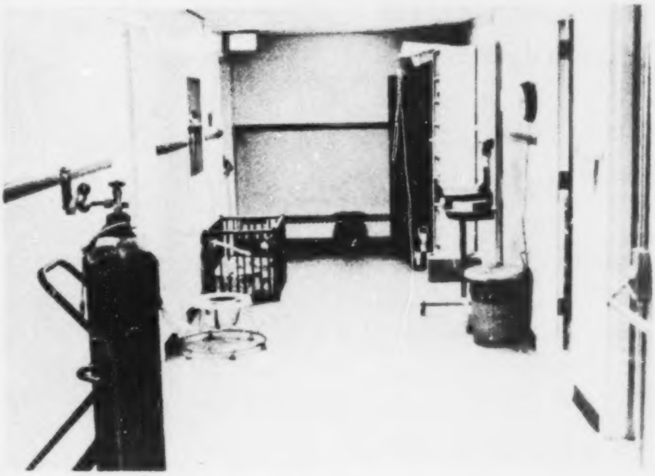
Corridor walls containing any openings such as pass throughs etc., must be a 1-hour rated assembly.

Hazardous areas must have two-hour protection and should be sprinklered.

Fire extinguishers should be placed in cabinets semi-recessed into the wall.

The addition appears to be in fair physical condition although the space utilization is inadequate for the program and function it services. Some space adaptations have been made to service the function but falls far short of needs and parameters of the programs.

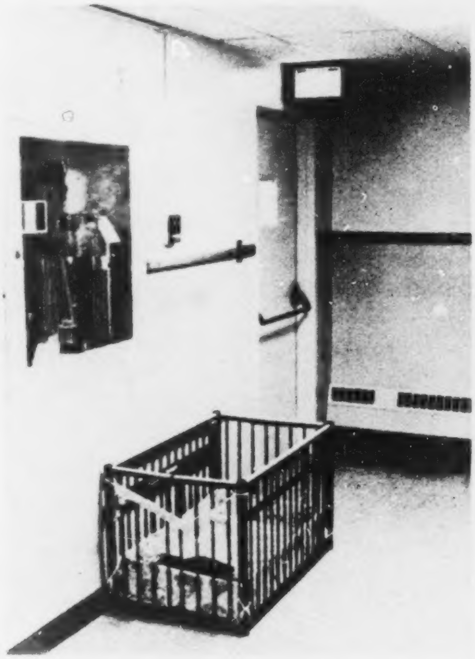
In an evaluation of both horizontal and vertical circulation, the distances are poor and cannot be corrected, but the vertical circulation could be improved.



Note obstructural exit way violates Code. No immediate available storage or play areas.

CORRIDOR IN PEDIATRICS AREA

Exit door width too small.
Vertical stair shaft only
at one hour protection.



Some new interior finishes will be required because of abuse and vandalism. Low maintenance materials should have been used.

Evaluation of Building "B" (Original Building, 1913)

Structural framework is wood frame with plaster and wood lath over (against codes).

Floors are of combustible materials as are roofs and walls.

Will not support required structural needs (100 lb/sq. ft.).

There is a number of Life Safety deficiencies that cannot be remedied:

Excessive dead end length (+20 feet);

Corridors are less than 8 feet in patient areas;

Corridor partitions are not an acceptable rated assembly (less than one hour);

Corridor doors are not labeled;

There are no smoke doors for separation;

Vision panels in corridor walls and doors must be wired glass;

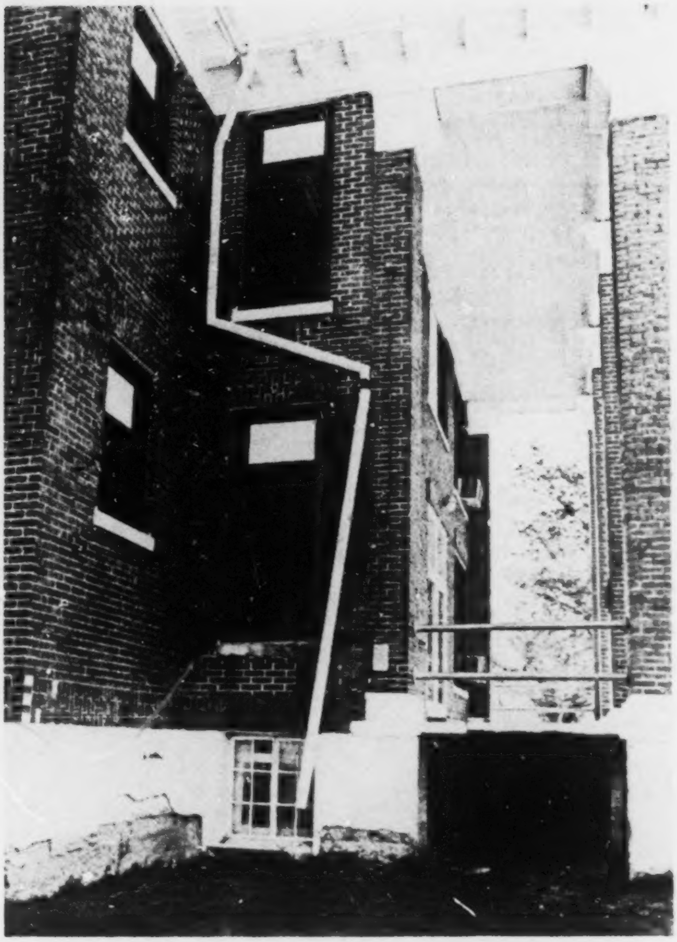
Exit door width must be 42" minimnum;

Basement exiting does not meet requirements for quantity, location or size;

Exam room doors are not of adequate size;

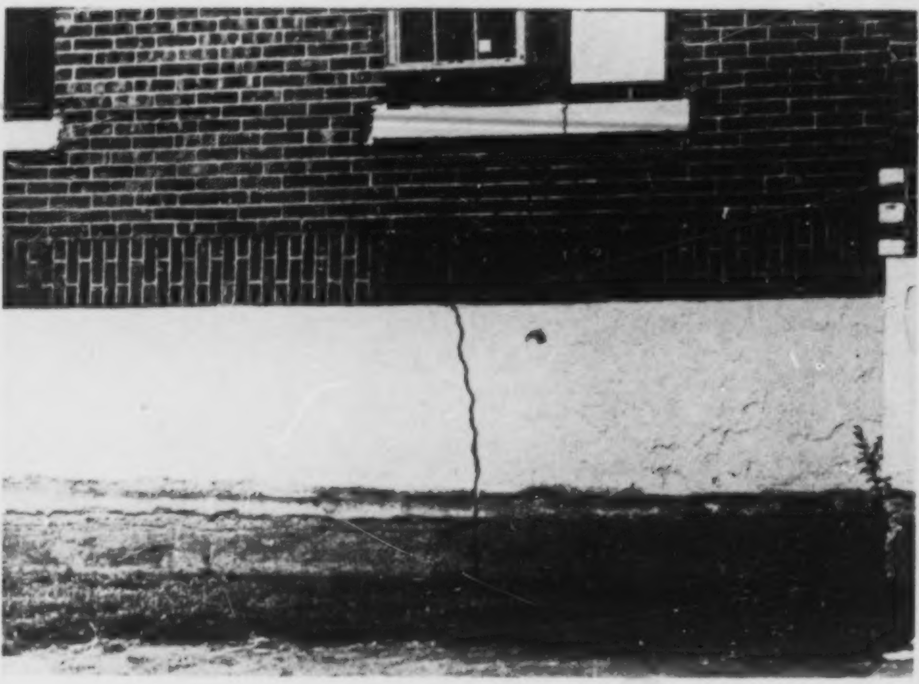
Exit stairs are to narrow and are not rated for two-hour assembly, (not sprinklered).

Hazardous areas must have two hour protection and should be sprinklered.



BUILDING B (1913)

Note exterior deterioration. First floor level not accessible from grade level by the handicapped for outpatient services.



BUILDING B (1913)

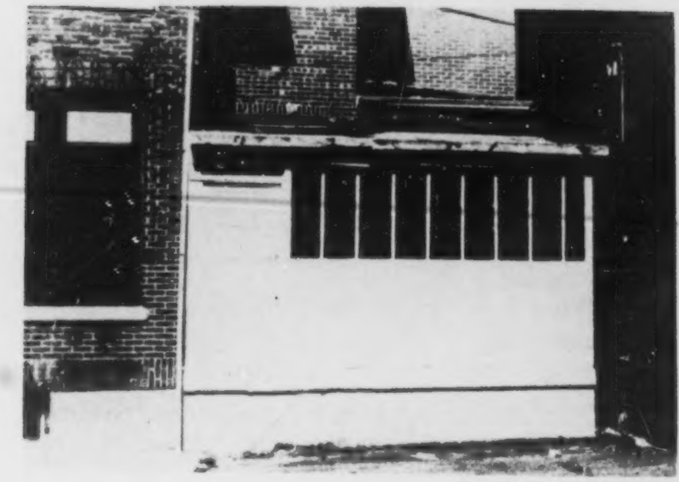
Note building deterioration from
settlement of foundations.

Waste processing was added on to the old building and does not meet standard construction requirements or health codes.

The original building is in poor physical condition and should not be used for a hospital facility. Most areas of the building, including the original elevator area, are in conflict with health codes and building codes. The Life Safety Code violations have been addressed in the previous statements. The age of this building does not allow any progress toward improving or correcting the code deficiencies. Hospital functions must not continue in this building because of the violations.

Corridor widths are inadequate and vertical circulation (shafts) are very poor. The useful life of this structure has been expended. The building is 68 years old.

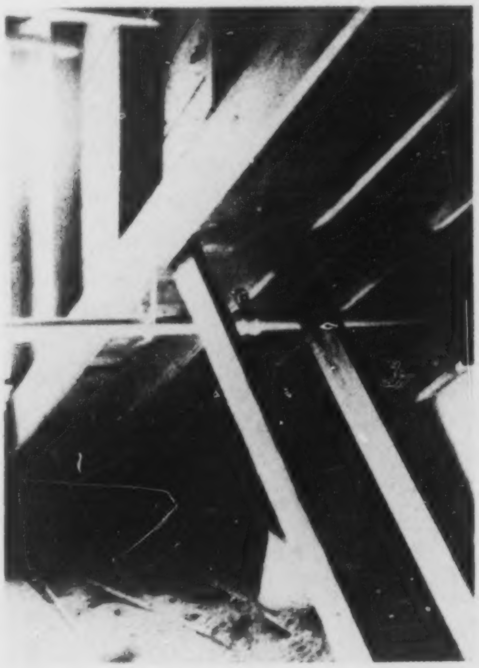
WASTE PROCESSING AREA

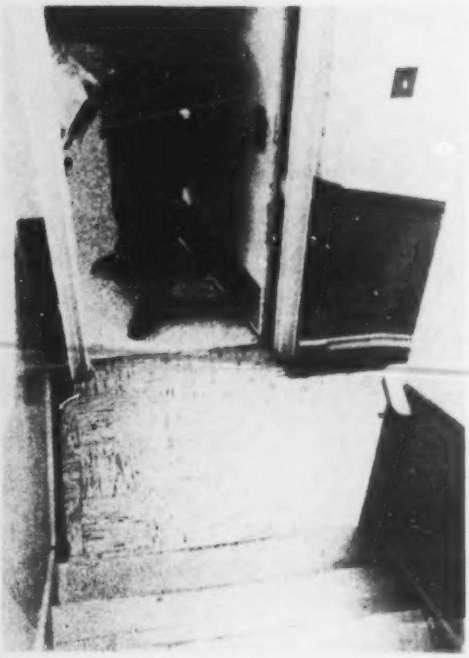


Added on to the building. Does not meet health codes or building codes.

BUILDING B (1913)

Combustible construction type does not meet building codes for occupancy type.





BUILDING B (1913)

Stairway exiting. Door swings the wrong way, stair too narrow, and not a two-hour rated vertical shaft.

Elevator does not meet current standards and is not accessible to the handicapped. Does not allow stretcher transport.

EXHIBIT #3 - MECHANICAL SYSTEMS DEFICIENCIES

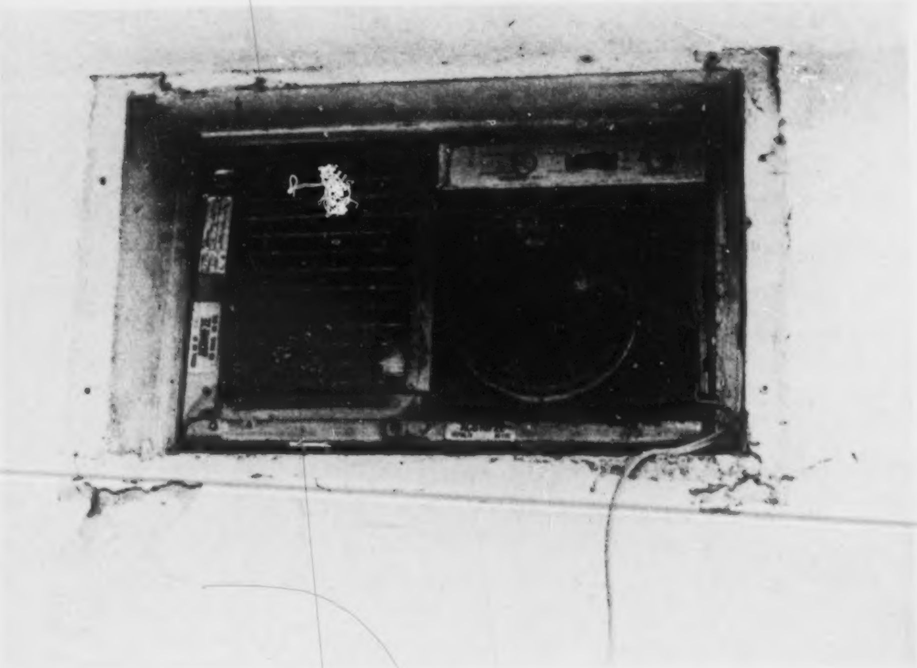
DESCRIPTION OF EXISTING MECHANICAL SYSTEM

CENTRAL PLANT

The entire facility (1913 & 1959 buildings) is heated with 2-100 H.P. high-pressure steam boilers (22 years old). Note: 1 boiler now (to maximum capacity) will handle the entire facility. The boilers operate at 60 pounds pressure (for sterilizers). The boilers utilize #2 fuel oil with 16,000 gallons of on-site storage. A pressure-reducing valve set at 15# provides low-pressure steam for heating the 1913 building. A steam to hot water converter is provided to heat the 1959 building with hot water heating. Domestic hot water is heated with the boilers and utilizes a heat exchanger (steam to water) and a domestic hot water storage tank. A detached 2-burner incinerator is provided on the site.

(1913 building) Cast iron radiators 2-pipe steam system is provided. In approximately 1978, self-contained automatic control valves were added to the radiators which have caused considerable maintenance problems. An automatic fire protection system was added in approximately 1972. Air conditioning is provided in some areas with window air conditioning. There is not any central ventilation (make-up air) provided in this building. Pipes in outside walls freeze and cause maintenance problems in winter months (masonry walls have deteriorated).

(1959 building) Heating is provided with hot water baseboard radiation with only 4 control zones in the building (First Floor east, First Floor west, Second Floor east, Second Floor west). There was not any central ventilation (make-up air) provided in this building for the exhaust systems. Air conditioning has been provided in the following areas with addition of a variety of systems.



LABORATORY AIR CONDITIONING

Note poor installation and building deterioration.

1. Kitchen and Dining (Free-standing DX system).
2. Emergency and Outpatient (window air conditioning units).
3. O.B. - Delivery - (A.H. Unit with DX system).
4. Surgery (roof-top unit) - 1981.
5. Medical Surgery Ward (roof-top unit) - 1981.

(Note on Medical Surgery Ward) there has been system adequacy problems with this unit and also the air is supplied into the patient rooms and returned through the corridor, which is a life safety code violation.

Radiology Area is not air conditioned and has continual overheating problems.

Only Storage Rooms and Hazardous Areas in the 1959 building have been sprinkled. (not patient rooms and corridors).

Patient room lavatories do not have wrist blade handles.

Piping has been a maintenance problem with continual leaks.

BUILDING ENVELOPE

(1913 building)

No wall insulation.

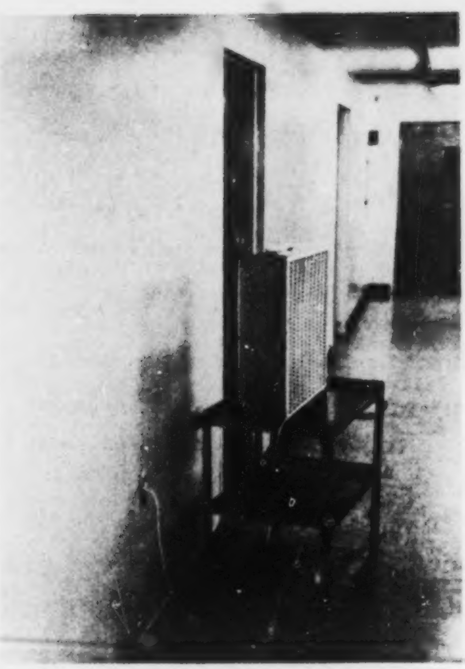
Insulation has been added in attic.

New windows have been added.

(1959 building) minimal insulation

1" wall insulation.

1½" roof insulation.



BUILDING A (1960)

Corridor and Nurses station ventilation.
Note inadequate building ventilation.

SUMMARY OF MECHANICAL SYSTEM DEFICIENCIES

The mechanical systems in the 1913 building are antiquated and its expected life has already been exceeded.

The mechanical system in the 1959 building is functional, except with the absence of required amount of ventilation air systems, absence of adequate controls, and absence of total air conditioning.

A continued up-grading of mechanical systems has been done in the facility but many deficiencies still exist in the mechanical system as listed in this report and previous IHS Documents.

Addition of required ventilation air will provide additional load on the boiler system and will require additional boiler capacity to maintain 100% standby as required by code.

The building (both 1913 and 1959) envelope is very deficient in comparison to present-day energy standards.

EXHIBIT #4 - ELECTRICAL SYSTEMS DIFFICIENCIES

ELECTRICAL EVALUATION OF EXISTING HOSPITAL

ELECTRICAL SERVICE

The electrical service is 208/120 volt, 600 ampere served by Cherry-Todd Electric Co-operative. Service entrance conductors and conduit are routed from pole mounted transformers to a main fusible switch. The electrical distribution system consists of a fusible distribution panel and a large quantity of individual disconnects that have been added to the main distribution panel. Circuit breaker type panel boards located in corridors and store rooms provide distribution for branch circuits.

In general, the electrical distribution system appears to be in good condition, except in limited areas. The conductors are all enclosed in conduit and appeared to be in usable condition, but in some of the older areas of the building, the conductor insulation is cracked and frayed, and should be replaced.

FIRE ALARM SYSTEM

The fire alarm system consists of a control panel, manual stations, audible and visible warning devices, smoke detectors and door holders. There are no duct smoke detectors and fan shut-down relays as required by The National Fire Protection Association 90A. Since the system is a collection of equipment from different manufacturers, such as Counch and Notifier, it cannot be UL listed as a system. Although there are some smoke detectors in corridors and store rooms, the quantity is not great enough to comply with NFPA requirements. The fire alarm system must have additional annunciators to comply with current requirements. In its present state, the owner indicated that the fire alarm system was operable.

NURSE CALL SYSTEM

The nurse call system consists of a visual-only annunciator with corridor dome lights and patient stations. Additional staff stations must be added in utility rooms, as well as updating the system to allow for ease of maintenance.

ISOLATION PANELS

The isolation panels in the operating rooms and emergency rooms consist of a transformer with a ground detector, as is commonly used in hospital installations of this era. This system does not meet NFPA current requirements for hospital installation. The equi potential grounding system does not appear to be present, nor are there any test reports to indicate that one has been installed in the past. The isolation panels in the intensive care and cardiac care area are in good condition and meet current NFPA requirements.

LIGHTING

In general, the corridor lighting and patient room lighting is adequate, consisting mostly of fluorescent lighting with surface wrap-around type fixtures. However, additional exit lights must be added in basement areas, the old existing building and in some corridors of the addition.

EMERGENCY GENERATOR AND TRANSFER SWITCHES

The emergency generation system was recently updated wtih a new generator and three transfer switches dividing the distribution system into the required branches. The emergency system appears to be in excellent condition. The emergency generation system serves the elevators, egress lighting, operating rooms, emergency rooms and intensive care areas.

SUMMARY

Although the existing hospital is quite old and the addition was constructed before many of the current code requirements, several remodeling projects have attempted to update the facility. Some of these remodeling projects include emergency generator installation isolation panels for the intensive care area, the fire alarm system and the electrical service. Additional updating in the future should include the nurse call system that will provide an audio-visual type system with additional stations throughout the facility, a complete new fire alarm system that will include fan shut-down and will be of the same manufacturer for ease of maintenance. The electrical service should be relocated to a separate area to avoid the high ambient temperature of the present boiler room. The lighting system in some areas requires updating to provide additional fluorescent lighting fixtures to bring the light level up to minimum requirements. The operating room and emergency room will require new isolation panels before they will comply with current NFPA requirements.

EXHIBIT #5 - SITE CONSTRAINTS FOR EXPANSION/MODERNIZATION

The existing hospital buildings are located on a site which is directly adjacent on the east to USIS Highway No. 1. This restricts expansion to the east.

The topography slopes steeply from north to south across the site. From its highest point to the north of the hospital, to the existing front entrance level, the site slopes approximately 42 feet in elevation. Any expansion to the north would therefore require extensive cut and fill sitework and would dictate several levels of underground levels to meet existing hospital levels.

To the south, the site continues to slope downward past the 1913 original hospital to several existing quarters buildings and maintenance building. Any expansion to the south would first necessitate demolition of the 1913 buildng and relocation of the maintenance building. The demolition of the 1913 building would necessitate relocating administrative, clinical, supplies, storage, and clinical exam service into the 1959 building. This would be impossible as there is no space available in that already overcrowded building. Disruption of services would be inevitable.

Expansion to the west is restricted by the location of all existing utility services to the present facility. Building in this area would cause major disruption to continued functions of the existing facilities. A new emergency generator building is also located to the west and would require costly relocation.

The balance of the adjacent site is restricted for hospital expansion by staff quarters buildings and service roads. The quarters buildings encircle the hospital, the west and south, blocking hospital expansion in those directions.

In summary, the present site does not allow for expansion of the existing hospital facilities without major disruption and relocations of existing service facilities which surround it. The major costs involved in demolitions, and relocations would seriously add to the costs of any significant expansion to the hospital facilities.

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Lillian Tom-Orme
Young Oak K. Pryor

W.I.C. Coordinator:
Evalina Williams

PROJECT REPORT

February 15 1982

This is a brief report to bring you up to date on the progress of the Salt Lake Indian Health Center. During the past quarter, the center has moved into primary health care. The Northwest Family Practice Center is giving us the services of a Physician Assistant for eight hours per week and a Psychiatric Nurse for four hours per week. In addition, we have a Podiatrist giving four hours per week and a Nurse that gives four hours per week on a volunteer basis. Finally, we pay an Optometrist for eight hours per month. With our staff comprised of a Nurse, WIC Coordinator, Clerical and administrative support, we provide the following health services:

a. General Health Clinics
b. WIC
c. Podiatry
d. Eye Clinic
e. Mental Health Counseling
f. Immunization Clinic
g. Blood Pressure Screening
h. Tuberculosis Testing
i. Diabetic Clinic
j. Prenatal Classes
k. Weight Reduction Program
l. Outreach and Referral
m. Family Planning
n. Well Child Clinic

Now that we are getting involved in primary health care, we are almost overwhelmed by the needs we are seeing. For example, two cases that came through the center last week are typical of the health problems we encounter.

First, a young mother two months pregnant came in seeking help for herself and her two-month old child she was still breast feeding. She had been selling her blood to survive in the city. The examination reveals acute anemia due to malnutrition and blood loss. Her infant girl was found to have a deformed ear due to a birth defect. It had come to the point where three lives were in jeopardy. Primary care was given and appropriate referral was made to the health and social service agencies in the city. We will be checking upon the referrals and expect to keep her as a patient until she is over her crisis situation.

Second, a teenage couple came into the clinic looking for help. She was seven months pregnant and had never seen a physician during that time. She was hemoraging and they were frightened. They did not know what to do. The young man's thought was to find someway to return to the reservation where his wife could receive medical attention. It is important to understand the distance it is from Salt Lake City to his home on the Navajo Reservation; it is approximately 450 miles away, roughly the same distance from Washington, D.C. to Atlanta, Georgia. This young man had a job to which he was adjusting with good potential of making an adjustment, but was willing to sacrifice this to help his wife in the only way that he knew how. Fortunately, we were able to provide the necessary health care so that it was not necessary for him to relocate. These two cases illustrate the critical need that the Salt Lake Indian Health Center is filling.

It makes absolutely no sense at all for the Federal Government to cut the small amount of monies, $8.2 million, for Urban Indian Health Care. According to the Utah Vital Statistics annual report, from 1968 to 1975 the median age of death for Indian people in Utah was 35.7 years, whereas the median age of death of whites during that same time was never below 69.0 years. Also the statistics between 1968 that came through the center last week are typical of the health problems we encounter.

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This is shocking evidence that prompted Congress to appropriate the money for Urban Indian Health Care in the first place. The statistics have not changed, and five years of the centers' operations have not significantly impacted the problem. In fact, we are just beginning to offer some hope.

It does not make any difference which political party is in the White House, or which political party has control of the House or Senate, or what their philosophy is, the Federal Government has historical, legal, ethical and a moral obligation to the American Indian people, no matter if they live on the reservations or in the cities. It was Federal policy that placed them on the reservations, and it was Federal policy that placed them in the cities.

Budget cuts are occurring at the State level to such a degree that it seems unlikely that the Salt Lake Indian Health Center will receive any monies to replace the Federal monies that we are now receiving.

One of our physicians points out the cost effectiveness of what we are doing with these examples:

(1) If we offer prenatal care to our clients, it will cost approximatley $500 per case. If an individual does not get proper prenatal care and a premature or sick baby results, the care could very well cost as much as a quarter of a million dollars. The Salt Lake Indian Health Center could run for two years on what it would cost for one neglected pregnancy.

(2) An infected ear that goes untreated could lead to chronic infection, loss of hearing, and meningitis. All of these sequelae are much more expensive to treat then treating the original infection.

Another one of our clinic staff writes the following:

(1) The Indians are afraid to utilize traditional care systems for several reasons:

(a) They are overwhelmed by the expense, i.e., $150 for an emergency room visit.

(b) They feel like they are standing in line to be seen, and then getting second-rate care at times. (Does it make any difference if a laceration is from a fight or an accident?)

(c) They are intimidated by language and culture barriers.

(2) The Indians seem to lack education on good health care practices.

(a) A young mother who puts off prenatal care for eight months, then in desperation seeks out a doctor to tell her when she is going to have her baby so she can leave for the reservation in time to have it under the Indian Health Service.

(b) A baby becomes dehydrated and dies because the mother does not recognize the importance of fluid replacement in dysentary.

(c) An unimmunized child gets sick from an easily preventable disease.

(d) Alcoholism, diabetes, TB, etc., continue uncontrolled because of inadequate screening, inadequate health education, and inadequate health care.

These problems are all approachable and in time preventable or treatable. It just takes the kind of an organization that is able to fill the very special needs of our clients. They need to be made to feel welcome and that we are glad to see, teach, and treat them.

We strongly urge you to continue your support of Urban Indian Health monies until we can secure other funding to keep our program operating.

CHIEF WASHAKIE

CHIEF BLACK COAL

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EUGENE RIDGELEY, SR.
Burton Hutchinson

REC'D JAN 27 1982

January 20, 1982

Honorable William S. Cohen, Chairman
Senate Select Committee on Indian Affairs
Washington, D.C. 20510

Dear Senator Cohen:

This is to confirm to you our telegram sent to you on this date that the Shoshone and Arapahoe Tribes appreciate the opportunity to comment on the impact that fiscal year 1982 budget reductions in Indian Health Service Programs will have on our reservation.

It is difficult to address this problem completely, as we have not yet received the fiscal year 1982 budget. However, based upon congressional action, we are submitting the attached testimony.

Sincerely yours,

Joseph Oldman
Chairman, Arapahoe Business Council

Alfred Ward
Chairman, Shoshone Business Council

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TESTIMONY OF THE SHOSHONE & ARAPAHOE TRIBES

On the Impact of Fiscal Year 1982 Budget Reductions on Indian Health Service funded & operated Programs

INTRODUCTION

Presently we are operating on a tentative 10% reduction from Fiscal Year 1981. We are aware, from the "History of Administration & Congressional Action" Indian Health Service document, that there are reductions which exceed 10%.

INDIAN HEALTH SERVICE FUNDED PROGRAMS

COMMUNITY HEALTH REPRESENTATIVE PROGRAM

We are apparently going to take a 21% reduction in this program. The impact will be felt in transportation of the elderly and handicapped to the medical facilities. Eye Glasses, E.N.T. (Ear, Nose & Throat), Dental, Nursing, Sanitation and Hemodialysis Service would all be reduced proportionately.

ALCOHOL PROGRAM

It appears on paper that a small increase was made; however, when considering the inflation rate of 18%, we effectively have experienced a funding reduction. The combined effects of the National Economy and the loss of local industry has adversely affected our alcohol problem.

TRIBAL HEALTH DEPARTMENT

A 10% reduction would reduce the staff to such an extent that monitoring of financial and program objectives would not be effective.

INDIAN HEALTH SERVICE OPERATED PROGRAMS

All Service Unit programs are interrelated. That is, a cut in one will affect another. All programs, both clinical and preventive service are needed to meet the Indian Health Service goals.

As an example, contract Dental Health care has been completely eliminated. This means that all children with dental problems requiring orthodonic care will not receive that service.

We find no programs within the Indian Health Service funded and Indian Health Service operated programs at the local level that can accomodate any reduction; these are direct service programs.

Reduction might well be obtained at the Area and Headquarters level in both Administration and Technical Support.

For example, the Billings Area Indian Health Service does not have a full time area office optomotrist. The program is still successful. This could possibly done in the Dental, Community Nursing, Nutrition, Health Education, Pharmacy, etc.

The C.H.R. program deserves special mention in that at one time the Service Unit Director served as the Project Officer. On the Wind River Reservation, this was a very satisfactory arrangement.

Less than a year ago, these duties were removed and were placed on a Billings Area Office Staff member who was not familiar with the Reservation nor close enough to provide the necessary technical assistance. This is an extra cost to the C.H.R. Program, where the prior arrangement was not.

Respectively submitted on January 20, 1982.
VIA TELEGRAM 1:15 p.m.

Joseph Oldman
Chairman, Arapahoe Business Council

Alfred Ward
Chairman, Shoshone Business Council